

Effective HIV/AIDS Interventions and Care for African Americans

By Randy Miller

Editor: Multicultural Training Resource Center

DRAFT

Overview

As we move further into the second decade of the struggle against HIV/AIDS, the epidemic continues to spread at an alarming rate among African Americans. Despite years of education in some communities regarding prevention, treatment and care, the rate of AIDS transmission continues to escalate in communities of color and in African American communities in particular. Many HIV-infected persons and others seeking to access services for the African American community complain that the few services that are available are largely targeted towards the majority culture. Because of this, the agencies and organizations which provide these services often do not offer effective models of prevention and care for African American communities and individuals.

This paper will examine some of the barriers to prevention and care experienced by African Americans seeking to access HIV/AIDS related services. We will also explore some basic assumptions regarding the provision of culturally-sensitive services. Finally, we will review several specific strategies for providing culturally competent services.

Barriers to Care

Many HIV-infected African Americans and others seeking to access services for their community encounter unexpected barriers to care. Some of these are listed below:

AIDS-Phobia. HIV/AIDS engenders feelings of fear, distrust and even anger in many people. This is largely due to ignorance about the virus and unfounded fears of casual transmission. Many HIV-infected persons find themselves the objects of discrimination and are often cut off from support networks such as family and friends.

Racism. This ranges from institutional insensitivity to the concerns of African Americans among care providers to the denial of treatment and care based on race. Stories such as the one-time widely circulated theory that AIDS originated in Africa through human contact with Green Monkeys or that Haitians or African Americans were more likely to be infected on the basis of race alone have fueled racial discrimination in combatting AIDS.

Homophobia or the fear/hatred of gay and lesbian people. The AIDS epidemic has fueled anti-gay violence and discrimination. Because the gay community was one of the first identifiable groups in the U.S. to succumb to HIV/AIDS and because many people to believe that gay culture is a largely white phenomenon, AIDS is often seen as a "gay white man's disease". This has in some ways fueled deeply held social biases and helped to escalate the levels of discrimination and violence experienced by many gay men and lesbians.

Moralism. Many HIV-infected persons are told directly or indirectly that HIV/AIDS represents a judgement on their lifestyle or sexual orientation. Such beliefs often keep HIV-infected people and their friends and family from disclosing the presence of the disease because of fear of stigmatization and ostracization. Ironically, this secrecy has the added effect of isolating persons affected by HIV/AIDS at the very time they most need their support networks.

Classism. Many of those hardest hit by the HIV/AIDS epidemic within the African American community come from lower socioeconomic levels in our society. In many cases these people come from marginalized subcultures about which our society is deeply ambivalent i.e. individuals below the poverty-line, injection drug-users, gay men, prostitutes, etc. In addition to these marginalized groups, the costs of treatment and care associated with HIV/AIDS overburden the financial resources of most HIV-infected persons. Many persons with HIV/AIDS find themselves impoverished by the costs of treatment and care.

An effective model for intervention and treatment must be cognizant of these barriers and utilize strategies that enable those seeking services to overcome or at least push through these obstacles.

Some Basic Observations

1. For a variety of reasons i.e. limited financial resources, distrust of healthcare institutions, and cultural beliefs about the healing and death, many African Americans do not access healthcare until a serious illness or problem has manifested itself. This has serious implications for diseases and illnesses such as HIV/AIDS for which prevention is relatively inexpensive and early intervention and treatment can measurably extend and enhance the quality of life.
2. Many African Americans because of limited resources do not enjoy the benefits of private healthcare and insurance. In many cases, HIV-infected persons must rely on already over-burdened public healthcare systems that in many cases provide substandard care and entail long-waiting periods. Many public healthcare facilities are not equipped to deal with HIV/AIDS in a manner that does not add to the stigmatization of the person seeking care.
3. Care Providers can not assume that persons concerned about HIV will come to them at the time when an intervention would be the most advantageous. As noted above for a variety of reasons, many African Americans delay seeking care until the illness or disease begins to manifest itself. Successful models of service provision must entail targeted outreach and recruitment and community-wide education about prevention and early intervention.
4. Many African Americans believe that HIV/AIDS is a disease engineered by human beings. Others add to that the virus was specifically engineered to deal with populations considered disposable by the majority culture. Such conspiracy theories cut across all socioeconomic lines in the African American community and are bolstered by actual historical events such as the Tuskegee Study in

which African American men with syphilis in the rural South went untreated for decades as a mode of scientific inquiry. Such historical occurrences have fostered a wide-spread distrust of the scientific and medical communities among many African Americans. This has serious implications in educating people about HIV/AIDS, a disease in which scientific and medical information is still emerging. Overcoming this distrust to provide prevention education and/or enrolling HIV-infected African Americans in clinical trials is sometimes exceedingly difficult.

5. Despite myths and stereotypes to the contrary, African Americans are as heterogeneous as any other subgroup within American society. What is perhaps distinctive from other subgroups is a conscious acknowledgement of shared history and culture and an awareness of the barriers that African Americans must overcome on a daily basis. This shared history and cultural awareness are important tools in designing effective intervention strategies.
6. In the discussion of culturally-specific and appropriate models of intervention and care for the African American community, the HIV/AIDS epidemic can not be viewed in a vacuum. Effective strategies for intervention and care regarding HIV/AIDS will take into consideration cultural history and norms as well as the other issues and needs impacting the lives of those seeking services. Too often HIV-infected persons must choose between dealing HIV/AIDS or other life issues i.e. substance abuse, housing needs, mental health issues, employment, etc. Effective intervention strategies will seek to link care for HIV/AIDS with services addressing other needs and issues.
7. Many African Americans reiterate time and time again their sense of isolation and loneliness and the lack of community support in dealing HIV/AIDS. As noted above, the fear of stigmatization and ostracization within the African American community are real barriers to seeking intervention and care. This isolation is particularly troubling because African American communities have traditionally recognized individual identity only within the context of family or cultural identity. Effective intervention strategies will seek to re-build peer support mechanisms for those who have been ostracized from more traditional support networks.

Providing A Culturally Competent Model

Modes of Service Provision

Outreach

Prevention Case Management

Treatment Advocacy

Community Events

Conclusion

**THERE SHOULD BE ONE QUARTERLY REPORT FORM FOR EVERY CONTRACT EXHIBIT.
ONE INDIVIDUAL CAN BE COUNTED AS ONE UNDUPLICATED CLIENT IN DIFFERENT
PROGRAMS DURING A SINGLE CONTRACT YEAR.
ANY CLIENT SEEN IN A NEW CONTRACT YEAR IS A NEW UNDUPLICATED CLIENT.**

Contract Agency

Fill in name of agency

Program

Fill in program name that the AIDS Office has provided

Contract Number

Fill in contract number

Funding Source

Fill in type of funding:

GF = General Fund

CARE I/F = CARE Title I Formula

State

CARE I/S = CARE Title I Supplemental

CARE II = CARE Title II

Other (includes CARE one-time funding)

Term of Contract

Fill in dates

Year (4 digits)

Quarter

Check the quarter for which you are reporting

Spring (January-March)

Summer (April-June)

Fall (July-September)

Winter (October-December)

Report Completed Date

Fill in date

Agency Contact Person

Fill in name

Agency Contact Phone

Fill in number

AIDS Office Program Manager

Fill in name

I. Units of service (UOS)

Actual Units of Service Provided This Calendar Quarter

Fill in number

Actual Units of Service Provided Contract Period-to-Date

Fill in number

Example:

An agency's contract year begins in July (Fall Quarter), and it provides 40 units of service in the Fall Quarter and 50 units of service in the Winter Quarter. In filling out the Quarterly Report Form at the end of the Winter Quarter, list 50 for actual units of service provided this calendar quarter and 90 for actual units of service provided this contract period-to-date.

II. Client Information

USE ACTUAL COUNTS FOR EACH ITEM. DO NOT USE PERCENTS.

A. NUMBER OF CLIENTS SERVED

- (A1) The number of individuals served this quarter
- (A2) The number of individuals served this contract period-to-date (unduplicated clients)
- (A3) The number of new individuals served this quarter

Note:

An unduplicated client is an individual person served within a contract period. This means that persons discharged, then readmitted to a program should not count as two unduplicated clients. If readmission is a significant issue for service providers, this information should be added to the Quarterly Report (e.g., 50 unduplicated clients served during the contract period-to-date, 5 of whom were readmitted during the last Quarter).

Example:

For the categories presented in item A: An agency serves 50 individuals during the first quarter. It serves 35 of these same individuals during the second quarter. In addition, 25 new individuals are served during the second quarter.

(A1): The number of individuals served in the second quarter is 60 (35 + 25).

(A2): The number of individuals served in this contract period-to-date is 75 (50 + 25).

(A3): The number of new individuals served in the second quarter is 25.

For all the following sections:

REPORT ON NEW CLIENTS FOR THIS CONTRACT PERIOD ONLY.

IN EACH CATEGORY, MAKE ONE CHOICE PER CLIENT.

TOTAL FOR EACH CATEGORY = TOTAL NUMBER OF NEW INDIVIDUALS SERVED = A3.

B. GENDER (Based on client's self identification)

- (1) Number of males served
- (2) Number of females served
- (3) Number of others served (include transgender)
- (9) Number of unknown served

C. SEXUAL ORIENTATION

BASED ON CLIENT'S SELF-IDENTIFICATION

- (1) Gay male
- (2) Lesbian (gay female)
- (3) Bisexual
- (4) Heterosexual
- (5) Declines to state
- (6) Unsure (client is unsure)
- (9) Unknown

D. AGE

- (1) 12 years old or younger
- (2) 13-17 years old
- (3) 18-24 years old
- (4) 25-29 years old
- (5) 30-39 years old
- (6) 40-49 years old
- (7) 50-59 years old
- (8) 60 years old or older
- (9) Age unknown

E. ETHNICITY

BASED ON CLIENT'S SELF-IDENTIFICATION

- (10) White/European American (Non-Latino/a)
- (20) African American (Non-Latino/a)
- (30) Latino/a
- (40) Asian/Pacific Islander
- (50) American Indian, Alaskan Native
- (60) Other . . . Specify [e.g., Caribbean (Not Puerto Rican or Cuban), Middle Eastern, African]
- (99) Unknown

Note:

If a client identifies with two of the ethnic groups listed above, list under "Other" and specify, (e.g., "African American /Latino"). An additional page may be attached if necessary.

F. LIVING SITUATION

- (1) Lives alone
- (2) Lives with dependent children (may include spouse, significant other or other relatives)
- (3) Lives with spouse/significant other (not including dependent children, but may include other household members)
- (4) Lives with parent or guardian (may include non-dependent children)
- (5) Lives with other relatives (may include non-dependent children)
- (6) Lives with non-relatives/shared expenses
- (7) Lives with non-relatives/no shared expenses (e.g., congregate living)
- (8) Homeless
- (10) Institutionalized (e.g., hospital, nursing home)
- (11) Incarcerated (e.g., prison)
- (99) Unknown

Note:

"Dependent children" are those who receive assistance or support from client or from the spouse/significant other of the client

"Other relatives" means relatives other than spouse, children, or parents

"Lives with non-relatives/shared expenses" means the client lives with non-relatives who share expenses and/or care

Note:

When more than one answer is applicable, employ the following hierarchy:

- Homeless (8)
- Lives with dependent children (2)
- Lives with spouse/significant other (3)
- Lives with parent or guardian (4)
- Lives with other relatives (5)
- Lives with non-relatives/shared expenses (6)
- Lives with non-relatives/no shared expenses (7)
- Lives alone (1)
- Institutionalized (10)
- Incarcerated (11)

G. GROSS MONTHLY INCOME

Gross monthly income is income before taxes. This report should be based on individual client's income only, not family income.

- (1) \$600 or Below
- (2) \$601 to \$900
- (3) \$901 to \$1200
- (4) \$1201 to \$2400
- (5) Above \$2400
- (9) Unknown

Note 1:

IF ONLY NET INCOME (AFTER TAX) IS AVAILABLE FOR CLIENTS,

calculate gross income by adding 10% to all monthly income between \$600 and \$1200, and 33% to monthly income over \$1201.

Note 2:

IF ONLY FAMILY INCOME IS AVAILABLE FOR CLIENTS, calculate individual gross income using the following conversion factors:

For a family of 2, multiply family income by .745.

For a family of 3, multiply family income by .544.

For a family of 4, multiply family income by .494.

Note 3: Food stamps are NOT counted as income.

Note 4: For those on Social Security, the amount of payment is the gross monthly income.

Example 1:

The client is a mother with two dependent children, and earns \$1,000 per month gross income. Her individual gross monthly income is .544 multiplied by \$1,000 or \$544 per month.

Example 2:

The client is an adult male living with and entirely supported by a lover whose take-home pay is \$850 per month. The gross family income is \$935 (\$850 + \$85). The client's individual gross monthly income is .745 multiplied by \$935, or \$696.57.

Example 3:

The client earns \$200 per month in gross income and lives with a spouse or lover who earns \$10,000 per month gross income. The client's individual gross monthly income is \$200 per month.

Example 4:

The client earns \$200 per month in gross income, lives with a spouse or lover who earns \$10,000 per month gross income. The couple has two dependent children. The client's individual gross monthly income is \$10,200 multiplied by .494, or \$5038.80.

H. EMPLOYMENT STATUS

- (1) Employed Full Time (35 or more hours per week)
- (2) Employed Part Time (less than 35 hours per week)
- (3) Not Employed
- (9) Unknown

Note:

For self-employed individuals, follow the guidelines suggested in items 1 and 2.

I. MEDICAL INSURANCE STATUS

- (1) Private insurance (includes HMOs such as: Bay Pacific, Bridgeway, TakeCare, QualMed)
- (2) Kaiser
- (3) MediCal/Medicaid (includes AFDC)
- (4) Medicare
- (5) Both MediCal and Medicare
- (6) Other public insurance (includes: VA, CHAMPUS, Indian Health Service)
- (7) Uninsured for medical treatment
- (9) Unknown

J. CLIENT PAYMENT FOR YOUR SERVICE

- (1) Client pays (out-of-pocket fees, whether insured or not)
- (2) Client does not pay
- (3) No fee for service (agency does not charge)

K. PRIMARY HEALTH CARE PROVIDER

- (1) Private practice and other HMOs
- (2) Kaiser
- (3) Community health center (includes county or free-standing community health clinic)
- (4) Hospital outpatient clinic (includes Ward 86)
- (5) Emergency room
- (6) VA military hospital outpatient clinic, or Indian Health Service
- (7) Other primary health care provider/Acupuncturist or Chiropractor
- (8) No primary health care provider
- (9) Unknown

L. HIV STATUS

- (1) HIV positive (not disabling)
- (2) Disabling HIV (includes ARC)
- (3) AIDS
- (4) Relative, friend or partner of HIV positive client
- (9) Unknown

M. SPECIAL POPULATIONS

- (1) Injection drug user (IDU)
- (2) Other substance abuse (including alcohol)
- (3) AIDS dementia
- (4) Mental illness
- (5) Mental illness and substance abuse (including IDU and alcohol)
- (6) None of the above

Note:

You are asked to report on a problem that affects the way you serve one or more clients. Report on only one problem per individual. If one individual would fit under categories 1 and 2, classify that individual as '1.' Category 4 'Mental Illness' includes any chronic mental illness that is not HIV related. Category 5 includes mental illness and all substance abuse.

**SUPPLEMENTAL INSTRUCTIONS FOR CBO'S WITH THE FOLLOWING PROGRAM
CHARACTERISTICS:**

- 1. The Community Based Organization has more than one program, and its programs serve an overlapping clientele.**
- 2. The contract year for the Community Based Organization ends in the middle of a quarter.**
- 3. The Community Based Organization contracts to serve clients that are not HIV positive.**

- 1. The Community Based Organization has more than one program and its programs serve an overlapping clientele.**

The AIDS Office requires that one Quarterly Report Form be submitted for every contract exhibit. This form will report information on those individuals that actually receive service. One client can be counted separately in two programs during one contract period.

Example:

A Community Based Organization serves 70 clients in the Fall Quarter. Thirty-five (35) of these clients are served in a Benefits Advocacy Program. Fifteen (15) of those clients, and another 35 clients are served in a Case Management Program. For the purposes of the Quarterly Report Form, the Benefits Advocacy Program will report on 35 unduplicated clients, and the Case Management Program will report on 50 unduplicated clients. Those 15 clients in both programs will therefore be reported twice to the AIDS Office.

- 2. The contract year for a Community Based Organizations ends in the middle of a quarter.**

Some contracts have expiration/renewal dates within a quarter. In these cases, two report forms (one representing each contract period) must be submitted during the quarter. The basic principle involved is this: **Any client seen in a new contract period is a new unduplicated client.**

Example:

An agency has a contract that ends April 30. As of March 31st, the program has 150 unduplicated clients. During April, the program serves 50 ongoing clients and 25 new clients. In May and June, the program serves 50 ongoing clients and 30 new clients.

NUMBER OF CLIENTS SERVED

Report I Summer Quarter Report for April [old contract year]

(A1) The number of clients served this quarter: 75 (50 + 25)

A2) The number of individuals served this contract period-to-date: 175 (150 + 25)

(A3) Number of new individuals served this quarter: 25

Report II Summer Quarter Report for May-June [new contract year]

(A1) The number of clients served this quarter: 80(50 + 30)

(A2) The number of individuals served this contract period-to-date: 80(50 + 30)

(A3) Number of new individuals served this quarter: 80(50 + 30)

- 3. The Community Based Organization contracts to serve clients that are not HIV positive.**

Agencies that contract to serve HIV negative clients should report these individuals separately from HIV positive clients. This may be done in two separate reports, or in one report with the two groups clearly demarcated.

4. What types of problems has the program experienced during the quarter, and what steps have been taken towards their resolution?

5. What quality Assurance (QA) activities took place during the quarter, and what were their results?
Describe any changes in program procedures resulting from your QA review.

6. Does your program maintain a waiting list? YES _____ NO _____
 - A) How long is that list?
 - B) What is the average waiting time?

7. Where does your program refer eligible clients who are awaiting services (include those not accepted onto a waiting list)?

8. Systemwide, what gaps in available services have you noted?

AFRICAN AMERICAN FOCUS GROUP
Januaury 25 , 1993

Introductions

Members present: Randy Miller, Carlton Jiggetts, and Nsomeka Gomes.

Discussion:

BAHSES and Each are both in the process of developing the drafts for the *Article and the Monograph*.

The Brochure has been completed. It will be sent to Sacramento for review. Thank you for your insights and expertise. I will forward you copies before we send them out for print.

We have interviewed two potential Video Producers. We will make our hiring decision by Feb. 17, 1993. Immediately after, we will schedule a focus group where we can all meet with him/her to further discuss production.

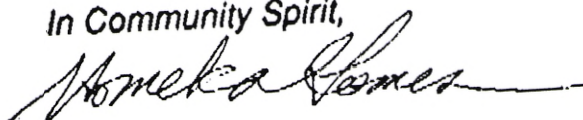
We expect to be in full production by the first of April. We hope you will be able to attend the focus groups and assist us in the development of this video.

All participants will receive a \$100. 00 stipend.

OUR NEXT MEETING: Friday , February 19th at 10:30am

We hope to see you there.

Peace ,
In Community Spirit,


Nsomeka Gomes



TO: Randy Miller

COMPANY: EACH

FAX #: 403-3809

OF PAGES INCLUDING THIS PAGE: 2

COMMENTS: _____

FROM: Nsamenka Gomes

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CONCLUSIONS

This report has summarized the result of our preliminary analysis of the AIDS-related KABB survey of blacks and Latinos in California . Our effort is by no means complete, additional analyses are needed. Nonetheless, the findings from our initial analysis can be put in context, and their implications for program emphasis and future research discussed. The study yields the following main findings:

- Blacks have a higher knowledge level of AIDS than Latinos. However, both blacks and Latinos have inadequate knowledge of how the AIDS virus is (or is not) transmitted. Among Latinos, those who have **higher fluency** in Spanish know even less about AIDS.
- Television news is the most frequently mentioned source of AIDS information but physicians/HMOs are more frequently perceived as being more reliable than any other source.
- Blacks and Latinos underestimate their risk of contracting HIV. This is partly evident from the high (19%) proportion who were grouped as high-risk heterosexuals compared to the low (5.7%) percentage who perceived their risk of contracting HIV to be greater than others.
- A high proportion of black and Latino women are at high risk of contracting the AIDS virus because their past and/or current primary partners have had sexual encounters with men, prostitutes, or injection drug users. Furthermore, most high-risk heterosexual women infrequently use condoms because of their partners' objection to condom use.

- Alcohol and non-injection drug [especially "crack"] abuse among California's black and Latino populations may pose higher risk of contracting HIV than non-prescription injection drug [e.g. heroin] use.

Most household surveys of the general population in California have reported high awareness and knowledge levels of HIV/AIDS. Our study reveals that blacks and Latinos in the state are not as knowledgeable about HIV/AIDS as they may have been perceived from the previous general population surveys.

Although blacks have higher knowledge of HIV/AIDS than Latinos, the depth of their understanding is doubtful. Inability by a considerable proportion of these populations (especially Latinos) to recognize that a person who has HIV/AIDS may look and feel healthy is disquieting, more so when these populations infrequently use condoms and underestimate their risk. Further, blacks are more likely than Latinos to doubt what doctors and health experts tell the public about HIV/AIDS prevention. This is confirmed by the fact that significantly higher proportion of Latinos than blacks perceived doctors as very reliable source of AIDS information. In addition, black females are more likely to believe that experts do not really know how the AIDS virus is spread. Latinos on the other hand are more likely to doubt public health experts because they found their prevention message confusing.

This study also documents pervasive misperceptions about the risk of casual transmission of the AIDS virus. For instance, respondents failed to make the critical distinction between donating blood and receiving blood. These misperceptions are bound to generate phobias and other socially undesirable consequences. Respondents who (a) perceived casual transmission as being possible, (b) who are less educated, or (c) who do not know someone who has or died of AIDS, expressed less willingness to work with people with AIDS.

These issues unequivocally indicate a need to provide well conceived, innovative, and culturally appropriate educational campaigns to increase the level of knowledge and counter negative attitudes among blacks and Latinos. Outreach workers in the black community have a challenging task of changing the current attitudes of suspicion and doubt of public health experts. These results further signify the need for research on appropriate approaches that may be adopted to relate medical facts to minority communities.

We propose that education and prevention programs should give high priority to Latinos who are **very fluent** in Spanish and the less educated members of the minority communities. These sub-populations are more likely to be poor, have low knowledge level of AIDS, have narrower range of sources of AIDS information, be less likely to think condom use is efficacious, and hold discriminatory attitudes toward HIV/AIDS patients.

Several studies have reported negative attitudes expressed toward persons with HIV/AIDS. These attitudes are equally rampant in minority communities. Discriminatory attitudes against persons with HIV/AIDS have far reaching research and policy implications. Although homophobia and the fear of contracting AIDS had been mentioned as the reasons for such attitudes, it is unclear if there are other factors involved. Whatever those reasons may be, given the widespread anti-HIV/AIDS attitudes, the time may be right to further protect the civil rights of persons with HIV/AIDS through anti-discrimination legislation. In addition, continuing education efforts should be directed at changing discriminatory attitudes against HIV/AIDS patients.

Our findings on the perceived reliability of source of AIDS information offer distinct opportunity for a shift in program emphasis. Television [news] is the most frequently mentioned source of AIDS information but only about one-half of those respondents think it is a very reliable source. From public health education perspective, it is doubtful that television news alone will achieve the goal of providing sound AIDS information. Part of the problem is that information provided by television news have different focus; they tend to contain more news than educational instructions. Our data suggest that MDs/HMOs, hospitals, and schools should be given more prominent roles in educating the public about AIDS prevention since these sources are perceived as more reliable than most others.

The result on HIV antibody testing within these populations indicate that testing has not been limited to those at high risk. There is, however, a distinct difference in the preference of test sites in both populations. Latinos sought testing at public health clinics while blacks seemed to prefer private doctors/HMOs. Those with higher education (at least some college) were more likely to have been tested. This information offers program planners the unique benefit of purposively aiming their prevention and counseling messages at these populations.

The scantiness of our data on intravenous drug users and men who have sex with men, should not be misconstrued to mean that these behaviors are relatively uncommon among blacks and Latinos. Rather, it underscores the difficulty involved in obtaining sensitive information through telephone surveys. Socio-behavioral researchers should be encouraged to design surveys that can accurately obtain sensitive information through representative sampling from these populations.

It is obvious from our results that the efficacy of condom use in preventing AIDS is well known in these communities. It is, however, doubtful if this knowledge has impacted behaviors, judging from the continued increase in STD rates, especially among blacks. Further research on condom use attitudes in the minority communities would be relevant. Such surveys must seek to obtain representative data on how condom use is negotiated between males and females, and circumstances or belief systems surrounding failure to use condoms during sexual intercourse.

One of the more striking findings from our study is that black and Latino women carry a heavy burden of risk from their associations with high-risk heterosexual/bisexual men. High-risk heterosexual blacks and Latino women were more likely to have been treated for STDs in the past year. High proportions of these women infrequently use condoms because such decision is made for them by their male partners. It is unlikely that these women are completely ignorant or irrational. They may be taking such sexual risks because of the lack of decision-making power, lack of alternative choices, or the fear of being perceived as promiscuous by their partners. In the light of all these, there is a critical need to develop innovative and culturally appropriate educational models for black and Latino women. We urge that such models emphasize social self-empowerment and negotiating skills training.



Multicultural Training Resource Center

Understanding Multiculturalism

Case Study: American Indian HIV Outreach Model

by:

Les Hanson

Editor:

Multicultural Training Resource Center

OVERVIEW:

According to the National Native American AIDS Prevention Center, men who have sex with men are still the fastest growing group of new AIDS cases within the Native American community. Statistically, homosexual men account for 54% of all Indian AIDS cases and the number of cases doubled in 1989. According to estimates by Emmett Chase, M.D., Director of AIDS Services for the Indian Health Service of the U.S. Bureau of Indian Affairs, "These rates will continue to grow at a similar pace for several years to come".

Indian men who have sex with men are clearly one of the most at risk groups for HIV infection. The 1990 San Francisco Department of Public Health sponsored San Francisco American Indian Male Study conducted by Fairbank, Bregman and Maullin indicated the following findings: 40% of respondents were raised on a reservation or other Indian Community, 87% of respondents felt that not enough is being done concerning HIV specific education and prevention interventions within the Indian Community, 67%

believe that anal sex with a condom is very high risk activity, only 8% were in a monogamous relationship, 20% engage in unprotected anal sex with other males, 73% use condoms only sometimes, 68% have difficulty talking to partners about condoms, 15% admitted daily alcohol use and 68% were unemployed.

There are many factors that put this target group at risk for HIV infection. One of the most crucial is substance abuse and its relationship in negotiation of safer sex practices and condom use. A large component of gay social life exists around establishments such as bars and discos, which serve alcohol. Some gay men who are in the closet, lead double lives. Many times even their families do not know about their sexual identity. Being uncomfortable with their sexual identity, substance abuse and alcohol relieves some of this anxiety.

It is compounded for Indian men. Issues of racism, high unemployment and poverty, low self esteem, personal image and society's perception and stereotypes of Indians are all reasons for the high alcoholism rates within the Indian community. The gay white community is perceived to be just as racist as its heterosexual counterpart. Many gay men need to lash out at the prejudice that they have experienced from the straight community, therefore the cycle of prejudice continues.

THE SAN FRANCISCO MODEL: "TOTO, I DON'T THINK WE'RE IN KANSAS ANYMORE"

San Francisco is looked upon as the last frontier for many people. For example, my family moved west in the 60s from South Dakota in search for a better life and opportunity. My Lakota mother, who was raised

on the extended reservation outside Rosebud, had convinced my father to move west. Similarly, many Indian men come to San Francisco for a variety of reasons. Some men go through a "coming out" process and become in touch with their suppressed sexual feelings. Here, they are able to try new things and experiment with new drugs and different types of sexual behavior. Living in a new city without a large Indian population, one can walk the streets with anonymity. One may "get lost" in the urban jungle and live life with no restraints or judgements imposed upon them by the family or tribal community. The saying that "we don't care what anyone does, as long as we know about it", is very true in small close knit Indian communities. Homophobia is very much alive and well in rural communities while the city offers tolerance and respect for difference in sexual lifestyles.

Coming from a rural area or reservation to the city is a big adjustment. The city can be mysterious and exciting. Many people arrive in their teens and twenties, some in their thirties and forties. But all feel that they have some catching up to do. Before coming, one always knows someone who has been there before and where the "skins" hang out. It doesn't take long to find the different segments of the Indian community. The areas are fairly defined and the meeting places were established long ago.

The downtown areas of San Francisco include establishments for Indian men who have sex with men. The Tenderloin, Polk, Civic Center and Mission are the main areas. Of course the Castro and other areas are included, but the largest concentration lies in the downtown area. San Francisco is unique in that the bars are able to cater to a specific subgroup within the larger lesbian and gay community. There are certain bars which are frequented by Indian men. Here, they are able to socialize and meet others with similar sexual desires. They come from all different walks of life and backgrounds. After living in the city for a season or two and having frequented the social scene, a newcomer begins to feel right at home and has developed a new circle of friends.

There are some unique aspects of this target group. Homelessness, and substance abuse are the most common. Many come to San Francisco and are

unable to obtain a job for a variety of reasons — the most common being substance abuse. Currently, HIV positive men have moved to the city to access better health care and social services offered within the "San Francisco Model".

However, access to health services is difficult for HIV positive Indian men. Issues of racism, substance abuse, health care costs, confidentiality within the Indian Health system, stigma of HIV disease and denial of one's own health condition has kept the HIV positive individual away.

AMERICAN INDIAN AIDS INSTITUTE OF SAN FRANCISCO:

The American Indian AIDS Institute (AIAI) was founded in 1988 to provide a coordinated community wide effort in order to educate individuals regarding AIDS prevention through risk reduction, and to help provide humane support for those Indian persons already infected with HIV. The overall mission is to reduce the level of HIV exposure and infection within the Native American community through culturally relevant and appropriate health education activities and events. AIAI provides and/or coordinates essential services to HIV infected individuals. The staff and Board of Directors are representative of the population served. Currently the agency has representation from 11 different tribal affiliations.

Initially, AIAI offered education and prevention services. The agency was able to offer direct services through the funding provided by the Ryan White Act. The expansion into direct services came at a time when more HIV+ Indian men were in need of medical services and case management of HIV disease.

AIAI identified certain gaps in the San Francisco Model of delivering services to the Indian community. AIAI found that Indian men for a variety of reasons, did not feel comfortable in accessing HIV services from agencies who were set up to primarily serve white gay males. It was critical that AIAI make contact with this hard to reach population and be there for them.

Another gap was the low number of Indian men who

know their HIV status. The need to get more Indian men tested is a high priority in delivering HIV services. People must know their HIV status in order not to infect others and begin living a healthier lifestyle to slow down the progression of HIV disease. But, throughout all the (9) Alternative Testing Sites (ATS) in San Francisco, not one Indian was a pre and post test counselor, nor was there any outreach being done in the City to give Indians testing information. Currently, AIAI has an Indian liaison who works as an ATS counselor and is available to talk to other Indians about the HIV antibody test.

For clients who test positive for HIV, continuing support for all stages of HIV disease must be available for them. It is important to tell our clients that being HIV+ does not mean that they have full blown AIDS. HIV disease is a progressive illness and through early intervention, this progression can be slowed down.

This brings us to our next component. AIAI is a part of the Gay Men of Color Consortium (GMOC). The Consortium is comprised of four agencies representing the "Big Four", that is the other Communities of Color within San Francisco. Namely the American Indian, African American, Asian, and Latin communities. We never use the term "minority" because in San Francisco, Communities of Color comprise over 50% of the total population. The term "minority" infers being less than, or substandard.

One of the programs which AIAI and the GMOC are a part of is the EACH program. EACH stands for Early Advocacy and Care for HIV+ Men of Color. We have an Indian Treatment Advocate who works closely with us by including our clients in the loop of information and treatment options available for HIV+ people. The Treatment Advocate helps clients monitor their health status and ensures that they are receiving medical treatment when needed. The EACH Treatment Advocacy also assists AIAI in the delivery of Education and Prevention workshops.

Another component of AIAI's program is the position of Early Intervention Liaison with the Center for Positive Care. The Center is a "one stop Shopping" for services related to HIV disease. The Center has over 15 different agencies all working under one roof.

This allows for the continuum of care which is so important for HIV+ clients. The Early Intervention Liaison staff person connects the Indian community with the variety of services offered at the Center. Traditionally, Indians have been left out of many collaborative efforts with other communities of color. AIAI gives high priority to collaborative efforts and coalition building. It has enabled AIAI to be included in programs such as the Center for Positive Care, which is the first of its kind in the United States.

OUTREACH PROGRAM IN DETAIL

One of AIAI's most important components is outreach. AIAI currently has two half time outreach workers. One outreach worker targets men and the other targets women and youth. The goals and objectives include increased awareness of HIV and promote behavior change by decreasing high risk sexual and injection drug use behavior. The second objective is to increase the number of individuals in the American Indian Community who can effectively identify the American Indian AIDS Institute and the services which are being offered to them if needed.

Outreach has many different definitions. It may be defined as handing out bleach and rubbers or actually bringing these services to the streets. AIAI has recognized that certain members of the community will never walk through the door, therefore, the services must be brought to them. This is no easy task.

First and foremost the outreach workers must be trained to deal with street life. Our outreach staff goes through a 10 day Community Health Outreach Worker (CHOW) training. The training includes 'almost' everything one needs to know about dealing with the mean streets of San Francisco. The best outreach workers are those who have been there and know what being "street smart" is all about. Usually, he/she is in recovery and has used the social services and shelters etc., which the outreach worker is now referring to clients. Many outreach workers have seen what HIV and or alcohol has done to them and or members of their families. A good outreach worker knows what the concept of "tough love" is and how to set boundaries between themselves and their clients. Outreach workers will be faced with a client,

for example, with full blown AIDS who doesn't have a place to sleep that night because of being 86'ed or unwelcome from all the shelters in the city. A scenario such as this happens all too often when dealing with a client who has a dual HIV and substance abuse diagnosis.

When a new outreach worker hits the streets, one of the first objectives is to start a routine and stick with it. Clients need to know when they can expect to see the outreach worker. Being consistent and showing up regularly will be the first step in developing a trust between the outreach worker and the person on the street. They will begin to depend on this outreach worker for certain needs. It may be for bleach and condoms, or it may be for the comfort of just seeing a familiar face who cares about them.

One of our Outreach workers is Navajo and does beautiful bead work. Her outreach bag has bead work all over. Indian clients on the street really identify with it. Sometimes, she is approached to answer questions about her beaded outreach bag. It is very important to identify with the population that one is trying to reach. Trust must be developed between the outreach worker and the client on the street.

AIAI's outreach includes utilizing culturally appropriate materials developed by the agency. Our outreach workers usually go out on the streets in groups of two. For safety and logistical reasons, this seems to be more effective. The outreach areas include other American Indian agencies, social establishments, and bars, parks and street corners. AIAI also works with other AIDS services care providers.

Drop off sites at bars, other social services agencies, are identified for brochure and flyer distribution advertising any AIAI event that may be coming up. Safe places such as cafes and grocery stores are also identified for outreach workers to go in case of trouble or to sit and talk with a client.

Field notes reflect the events of the day and are used to track a client to measure any improvement or change in a confidential manner. Record keeping and reporting of number of contacts is required for statistical purposes. Field notes are also used in contract reporting which include a weekly, monthly, and quarterly report to satisfy the contract reporting require-

ments from our funding sources.

OUTREACH PROGRAM EXAMPLE

Outreach is vital for a hard to reach target group such as Indian men. Listed below is an example of our outreach programs goals and deliverables taken from a currently funded contract.

PROGRAM GOAL

To increase knowledge about and reduce the transmission and infection rate of HIV disease in the San Francisco American Indian community.

MEASURABLE OBJECTIVES:

OBJECTIVE #ONE:

To recruit and train two (2) new health outreach workers, including two from the three targeted segments of the Indian population (below), who will effectively conduct street-based risk reduction outreach in the Tenderloin/Turk street area, the Mission/Valencia street area and the Civic Center area during the first year:

- Men who have sex with men, including Intravenous Drug Users and homeless
- Women, including IVDUs and homeless women
- Men who have sex with women, including IVDUs and homeless men

ACTIVITIES:

Job announcements for an outreach worker will be sent to the all the Indian owned and managed agencies and businesses in the San Francisco Bay Area. By the end of the first contract month, (2) outreach workers will be hired and trained by AIAI staff in demographical information and will participate in the C.H.O.W. (Community Health Outreach Worker) training sponsored by the California AIDS Intervention Training Center.

By the end of the third month, the project coordinator and outreach worker from the respective sub-popula-

tion in the Indian community, will conduct 3 focus groups: 8-15 participants in each group, 90 minutes in length, to develop an outreach curriculum that is Indian specific and culturally appropriate for each of the above sub groups. The data collected from the focus groups will be analyzed and utilized to create a pilot Prevention/Education HIV/AIDS "Train-the-trainers" outreach curricula.

In turn, the pilot run will test the curriculum's effectiveness on (8) individuals from each sub population (24 participants) in the Indian community. Adjustments, if any, in the curricula will be made based on the pilot-run findings by the end of the sixth month.

OBJECTIVE #TWO:

To recruit and train five (5) new health facilitators, who will effectively conduct HIV/AIDS risk reduction workshops among the three sub populations of the American Indian community:

- Men who have sex with men, including Intravenous Drug Users and homeless
- Women, including IVDUs and homeless women
- Men who have sex with women, including IVDUs and homeless men

ACTIVITIES:

By the end of the sixth month, the (2) outreach workers will work aggressively through community networks (community centers, community-based clinics, pow-wows, etc.) to identify persons who are respected, influential peers in the community to be recruited and trained as facilitators of the HIV/AIDS risk reduction curricula. The curricula's effectiveness will be tested on the 5 new facilitators and adjustments will follow, as needed, by the end of the seventh month.

By the end of the eighth month, three (3) risk-reduction workshop curricula will be developed targeting the (3) sub populations.

OBJECTIVE # THREE:

To implement a HIV/AIDS Prevention/Education model which includes 20 hours per week of street-based HIV/AIDS prevention/education risk reduction outreach to 60 individuals per week, and 5 risk reduction workshops attended by 40 individuals.

ACTIVITIES

The two outreach workers will conduct street-based risk reduction outreach by one-on-one and/or group encounters in the Tenderloin/Turk street area, the Mission/Valencia street and the Civic Center areas while many hard-to-reach, high risk Indians frequent (social services, parks, bars, eating establishments, etc.) and/or inhabit .

Using the HIV/AIDS risk reduction workshop curricula, the 2 outreach workers will hold house parties, special community events, dinner parties, etc. in private homes in the Indian community.

OUTREACH EVALUATION: SUCCESSES AND FAILURES:

The evaluation of a program is very important and must be done systematically in order to measure any improvement. Program evaluation must be looked upon as constructive criticism. It is the time to evaluate what works and what doesn't work. But this is all relative for those who believe that " It all depends". Each and every client case has its own set of circumstances, and must be approached accordingly, so how do you do an effective outreach evaluation?

Well, before that can happen certain procedures must be in place. HIV disease within the Indian community still has a great amount of stigma attached to it. Community members frequently talk about who is positive and confidentiality is not always honored. This brings us to the issue of policy and procedures.

It is imperative that the agency have current office policies and procedures in place that are strictly followed. All staff must sign a confidentiality statement and honor it while outside the office. If the agency has the reputation of telling community members who

is HIV+, clients will not access services.

Documentation and contract reporting is another vital element of running an effective program. Contract reporting is time-consuming and cumbersome at best. However, funders demand reporting information and will eliminate a contract, if reporting requirements are not met. Therefore, all staff must keep certain reporting information on the clients they see. This can be done by each staff member submitting a weekly narrative and statistical report. (See example below) Submitting a weekly report makes the monthly and quarterly report easier to compile. Also, staff compliance and accountability, program deliverable problems and program changes are addressed in a much more systematic and quicker fashion than waiting for the quarterly report.

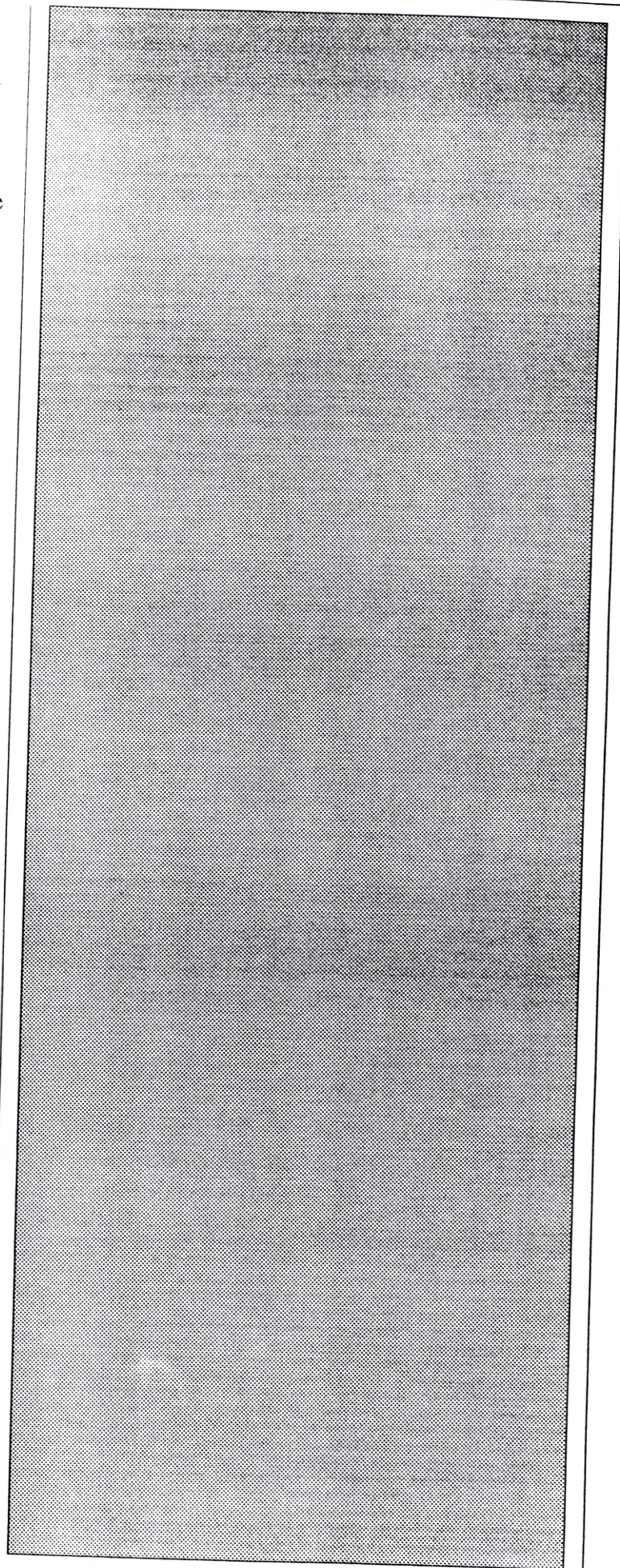
Peer education and participation which has been a direct result of the outreach component has been encouraging. AIAI has had a strong response from volunteers wanting to offer their time and assistance to HIV prevention education. Peer education is vital in helping others to change their high risk behavior.

AMERICAN INDIAN AIDS INSTITUTE INTO THE 90'S

Looking into the future, AIAI will expand services to promote the new concept of "peer prevention case management," i.e., community members watching out for and assisting each other in maintaining seronegative status.

It has been shown that certain people relapse into unsafe behaviors. Relapse occurs for a variety of reasons. Peer prevention case management will address these various issues and offer continuous support for men to practice safer sex.

As we enter into the second decade of living with HIV/AIDS, a whole new generation of Indian men will be coming of age and beginning to explore their sexual identity. It is our responsibility to ensure that they are well informed about HIV/AIDS concerns and are given the means to protect themselves from HIV disease. The only prevention available is through education.



OUTREACH REPORTING FORM

Weekly Narrative and statistical Program Report

To NTFAP - OMH Grant
25 Van Ness Avenue, 5th Floor
San Francisco, CA 94102

From: American Indian AIDS Institute
333 Valencia Street #200
San Francisco, CA 94103

Contract Number: NTFAP-OMH/ Street Outreach
HIV Education Prevention Education

Contract Period: _____

Period Covered: _____

Today's Date: _____

The following is a report on all services associated with the Street Outreach and train the trainers Curriculum Development and implementation programs for HIV+ Native Americans.

Deliverables	Projected for Year	Provided This Week	Provided YTD
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Hours of Street Outreach	20 per week
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Number of Persons Reached	60 per week
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# of Workshops Held	5
---------------------	---

# of Participants	40
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Hours of Curriculum Dev.	
--------------------------	--

# of Focus Groups Held	3
------------------------	---

# of Facilitators Trained	5
---------------------------	---

Narrative: _____

I certify that the information provided above is to the best of my knowledge, complete and accurate.
Full justification and backup for these claims is on file in our office.

Signature: _____

Title: _____

Date: _____

American Indian AIDS Institute Services Summary

Case Management:

Services for HIV+ clients include:

- Client Advocacy
- Substance Abuse Recovery Support/Referral
- Early Intervention Treatment Advocacy
- Risk Reduction Education
- Benefits and or/Tribal benefits Counseling
- Supplementary/Traditional Healing Advocacy
- Clinical Trials Advocacy
- Housing, Food, Clothing, Basic Needs Referral
- Additional Information and Referral

Psychosocial Support:

Services for HIV+ clients include:

- Group support (8 week sessions)
- Individual one-on-one counseling

Practical Support:

Services for HIV+ clients include:

- Practical Support Attendants
- Peer Emotional Support Attendants
- Nutritional Guidelines
- Infection Control

Prevention and Education:

Services for the Indian Community include:

- AIDS 101 trainings to:
 - the General Indian Community
 - Men who have sex with Men
 - Injection drug users and their partners
 - Women and Youth
 - Health Service workers who serve Indian populations
- House Parties on safer sex information
- Hot, Healthy and Horny Playshops for Men who have sex with men
- Community wide Dinners, Dances events with AIDS 101 presentations
- Agency Booths/tables at Pow Wows, film festivals, art shows, sports events and other Indian specific

gatherings

Outreach:

- Street outreach targeting Indian men, women, and youth

References

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Multicultural Training Resource Center

Understanding Multiculturalism

The Latino Community and AIDS Prevention

by:

Mario Hernandez

Editor:

Multicultural Training Resource Center

The purpose of this paper is to address some issues regarding cultural staff development in agencies that provide services to Latinos. The issues that will be discussed are as follows: management profile, staff profile, appropriateness of materials, networking, program methodology, funding and cultural literacy. These issues will be presented in a manner that will assist the reader in better understanding ways of effectively disseminating information about HIV disease in the Latino community.

First, one must realize that the Latino population in the United States is heterogeneous, with much diversity in national origins, political ideologies, values, cultures, community settings and geographical locations. Within each Latino community there exist different social groups and behavior patterns.

Among the social situations that impact the problem of AIDS in the Latino Community are: life in the inner-city, urban environments; life in rural environments for migrant workers; migration to/from the United States to Mexico/Central America and Puerto Rico; and undocumented workers living an underground existence.

The following are some suggestions that might be utilized by programs proposing to do work in Latino communities on AIDS Education and Prevention in order to facilitate effective strategies.

Management Profile

The ideal situation for the Latino populations is to be provided with an AIDS Education and Prevention program which is effective in addressing their needs. This implies that a Latino be employed as the manager or coordinator of a Latino program. The years of experience that a person has gained working in a distinct community needs to be assessed and considered in addressing the qualifications of management staff.

The management of an organization must realize that incorporating a program that is targeted for Latinos means not only developing a staff profile which is reflective of the client population to be served, but also changing the complete structure of the organization. In some cases it may mean shifting the philosophy of the organization to incorporate a more multicultural perspective. Existing management must be willing to learn and willing to include more Latino culture into their personal and organizational structures. Latino management staff must be granted the freedom and be shown the confidence in their ability to make decisions regarding the culturally relevant aspects of their programs.

"In order for the new program to succeed, linkages with other departments of the organization need to be carefully planned and orchestrated. All existing departments of the organization need to be informed about and incorporate the new program into their own structure in order to ensure its success. Management also needs to be prepared to allocate adequate and proportional resources to the

new program,"

Roberto Garcia, Latino Volunteer Coordinator, Shanti Project, San Francisco. Management cannot presume that the methods used in the Latino community will equate in the same fashion in terms of units of service to other populations. Management needs to realize that since the form and the content of a Latino program is different, the measure of the program will also be different. For example, staff may be required to work mostly late evening hours in order to access particular segments of the Latino community. Consequently, some of the service requirements placed by the funding sources may be outside the realm of established core programs and may unnecessarily overburden the organization.

There must be clear lines of communication that flow both from the management of the organization to its staff and vice-versa. As much as Latino management will need additional support and plenty of leeway, it may also need guidance and technical assistance in regards to program evaluation.

Staff Profile

Efforts should be made to hire staff who are representative of the population that is being served. There is little credibility otherwise. It is beneficial for the staff to have supervision from a person in management with whom they can identify. Therefore, management needs to develop an employment policy that addresses the importance of inclusion. Latino employees should participate in establishing the agency's hiring criteria and employment policy. Lack of this valid participation could jeopardize the success of the program.

The staff must be bilingual and trained in culturally competent AIDS education. The staff training needs to include workshops, inservices, and testimonials dealing with issues of human sexuality, racism, xenophobia, sexism, and drug addiction. Sensitizing staff as to how these issues manifest themselves in the Latino community will prepare them to relate better with such situations once they are out in the community.

Management must recognize the dual role of staff as educators of the client as well as of other staff members. They will be asked to develop and set protocols, find loopholes and shortcuts to ensure access to

services for their clients. Therefore, management needs to allow some leeway and be supportive. There needs to be established mechanisms by which staff can inform management of obstacles being confronted in the work field. Staff input on how programs are created and evaluated must be incorporated.

Appropriateness of Materials

A fundamental need, and present gap, in Latino based education and prevention programs, is the availability of good, basic, sensitive information material which reflects the diverse aspects of the Latino community. Because Spanish usage patterns in the United States comprise at least seven Latino subgroups, it is sometimes advisable to adapt the text to a neutral, universal, simple, and grammatically correct language that can be understood by all or most subgroups. However, in most cases it is more advisable that educational materials be culturally specific and sensitive to country of origin.

Prevention campaigns need to include some core Latino cultural values such as family (includes the sense of obligation to provide emotional and material support to members of the extended family); collectivism (reflects the importance assigned to friends and members of the extended family who provide companionship and help solve personal problems); respect (addresses the need to maintain and defend one's personal integrity and to allow face-saving strategies whenever conflict or disagreements arise). These core values are imperative in order for a campaign to be perceived as being relevant to Latinos. We know that literal translations from English to Spanish do not work. Once materials are developed they must undergo testing with Latino focus groups to ensure cultural appropriateness.

Networking

The ability of the staff of an organization to network is of vital importance to the success of an HIV Education and Prevention program. Both management and staff must become familiar with and within existing networks of AIDS service providers. One reason is to avoid the duplication of existing services, but more importantly, incorporating a program into existing networks will allow for the creation of memoranda of

agreement with other agencies that can facilitate compliance with contract obligations. Partnerships between community organizations and governmental agencies at all levels are essential. It is also important for surveillance and research purposes, to support universities in collecting selective data in order to collaborate with AIDS agencies.

Once in the network of service providers, it is important for management to maintain an active role in the network and to involve the community and other community based agencies (C.B.O.s) in the development of People of Color and/or Latino initiatives to ensure that they are culturally and organizationally appropriate. Management should also try to integrate HIV prevention and substance abuse initiatives at the federal level and state level to facilitate local integration of services.

In developing multinational networking coalitions, Latinos should be allowed to send materials and provide presentations to Latin America.

Program Methodology

Prevention programs must examine how they are incorporating cultural influences in their work with the Latino community. If the impact of cultural strength is being ignored, programs must be redesigned to tap the tremendous potential of using culture to protect individuals from risk factors. Prevention and intervention efforts, to be more effective, should be targeted to include the entire family unit (traditional or alternative). Prevention campaigns need to focus on behavior, rather than on groups of people, and men and women should be depicted as being equally at risk. Prevention programming must be developed to reach Intravenous Drug Users (I.V.D.U.s), homosexual and/or bisexual Latinos to the degree that these populations are being affected.

Small group discussions, theater presentations, mobile clinics, peer health education and popular adult education are existing models that have proven successful within the Latino community. Reinforcement of the HIV prevention messages by the media, particularly radio programs amongst Latinos are essential to curtailing the spread of HIV disease.

Program management and staff need to aggressively

seek out technical assistance and locate funding opportunities to maximize their proposal writing. They should not hesitate to ask for assistance in identifying needs, resources and funding for prevention.

Funding

On a federal level, monies are being shifted toward treatment and care at the expense of necessary prevention programs, hence the need to maintain funding for prevention and behavior modification programs. Funding should be sought out for a major ethnic-specific media campaign and especially for radio programs.

Staff, Clients and volunteers should be allowed to do fundraising specifically for the program and designate funds for that program. "It is critical that the management of an organization allocate equal resources to AIDS education programs in comparison to its other programs," states Jesse Johnson, Program Coordinator, Education Modules for Community Change of the National Taskforce on AIDS Prevention. Programs should seek ongoing funding for peer educators through stipends. They also need to budget for child care.

Cultural Literacy

Latinos living in the United States are a heterogeneous population. Each Latino group has brought from its native country a unique ethnic background — history, culture and religious beliefs — that has evolved and endured over centuries. Lack of awareness and sensitivity to this fact can build formidable barriers in reaching Latino audiences. Many immigrants from war-torn areas of Latin America suffer from post-traumatic stress syndrome, which must be dealt with before HIV education can be effective. Special support is needed to help these families recover. Typically, the Latino family is group-oriented, even in the decision making process. The emphasis on family encourages members toward interdependence.

Even though Latinos are the fastest growing ethnic People of color in the United States, they are less likely than their Non-Latino, White and Black counterparts to seek out medical attention. Cultural

factors ranging from difficulty in speaking English and fear of medical technology, to lack of medical insurance and fear of deportation contribute to the lack of access to health care systems, particularly prevention programs.

Simply translating English into Spanish does not meet the criteria for culturally, educationally and linguistically appropriate messages. Therefore, programs need to target specific subgroups (e.g. migrant farm workers, sex industry workers, gays and bisexuals). The strong sense of family needs to be taken into account and effectively used.

In sum, Latinos living in the United States are a heterogeneous population. Certain social situations impact on the problem of AIDS in the Latino community. These include life in the inner-city, life in rural environments for migrant workers, and undocumented workers living an underground existence. The management of an organization must realize that targeting Latinos means not only hiring staff who are representative of the client population to be served, but also changing the complete structure of the organization. In doing so, it is important that educational materials be culturally relevant and sensitive to the country of origin and that the text be neutral, simple and grammatically correct. The ability of the staff to network is vital to the success of an HIV education and prevention project.

Latinos comprise approximately 8% of the total United States population, but represent approximately 16% of the total number of AIDS cases, including 21% of AIDS cases among women and 22% among children. It is apparent that Latinos are, on a per capita basis, disproportionately affected by HIV disease. It is my hope that the information presented in this paper can help curtail the current trend of infection in the Latino community.

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3-17-93

Draft

Culture is the values, beliefs, linguistic expressions, pattern of thinking and styles of communication that shape our behavior and expectations. It is shared by a group of human beings as expressed through behaviors in response to the specific needs of its members. It goes beyond race and color to include ethnic physical characteristics and groups with similar values, experiences and orientations/preferences.

Culture plays a very important role when we talk about education in any specific group. When designing a curriculum that is inclusive of other cultures, we will have to consider the implications that it will have on the members of that specific group. Each community has its own definitions of what is acceptable when discussing illness or sex and these definitions have to be considered and respected. An effective educational program will include a diverse mechanism to empower those it will serve, it will also include their cultural and ethnic backgrounds and it will serve as a bridge between the communities and their service providers.

This video addresses some important factors to consider when communicating with the African American community. It is clear that in this community, respect, family, and tradition go hand in hand. For example, ~~it is known that~~ ^{community is highly valued} respect in the African American community is considered one of the highest honors. Once the community feels a lack of respect, regaining its trust is very difficult. You will have the opportunity to listen to these points as well as other important points made by African Americans when they share their personal experiences.

This video will attempt to explore many of the cultural factors that make the African American community unique. It is our hope that it will assist you in your effort to communicate with and to serve the diverse members of this community.

Through this video we hope that you will:

- recognize the inadequacies and shortfalls in attempting to apply a standard but limited outreach model as a blanket approach to all cultural communities
- understand the basic ^{cultural values} ~~differences between various people of color communities and,~~ ^{in the AA community}
- recognize the benefits in utilizing culturally appropriate methods of communicating with or addressing the African American community.

In an attempt to give you an **overview of the cultural community** will mention that the African American community is a heterogeneous one. There is a wealth of diversity within the Black community. You will find differences in religious, political and philosophical beliefs, in lifestyles and life experiences, in sexual orientation and preferences, in language, in communication styles and in geographic origins. However within the African American community there are some common values and folkways that stand as a monument to the cultural framework. Although the system of chattel slavery and forced assimilation has had a destructive impact, distinct mores, attitudes and beliefs have survived, giving this community a rich, diverse and viable cultural identity.

(video: overview of the community)

In African American communities ~~rules and regulations are clearly defined and although the norms vary from one community to another, they are clear to the members of each community.~~ When someone tries to do outreach to the African American community the best way to receive cultural credibility is by either bringing a leader of the community or by empowering the members of this community to do the outreach. Of these two, the latter, is the best strategy to follow. This is why it is advisable to develop focus groups to inquire about the best way to reach each community.

**African Americans wait to go for health care*

**Sexuality or sex education is not discussed in public setting*

**women are the decision makers primary caregivers*

**religious community (commonality)*

African Americans have acquired some information about AIDS, but unfortunately education in this community is behind. There is a lack of awareness among women about the risk of HIV associated with sexual practices. There is still a myth or misperception held within the African American community that HIV/AIDS "is not our issue," that it doesn't affect African Americans and that only IDUs and homosexuals get it. Due to the long history of racism, there is a great suspicion and fear among African Americans about the medical system, doctors and other health care providers. In result of this mistrust, many African Americans do not start receiving direct services until they are in the very acute stages of HIV/AIDS. The **knowledge** acquired by some African Americans have not been culturally appropriate and the largely scarce funds that these

communities receive to take care of their education and prevention programs results in the backlog on information and the rising in the numbers of HIV/AIDS cases.

***one to one education is better**

***presentations should include- child care, transportation
find out educational level- for pre/post test**

***radio program**

***condom demonstration in a fun way- take it to their homes**

***do not assume that your group knows what to do** *or condoms*

***visual by Emma (use some of them)**

***translations (Cheryl and Mario)**

***know your target group**

***homosexuality (Emma and Mario)**

-0-

In this community as in other communities the attitudes and beliefs are closely related to the value system. The values in most of the Latino communities are consistent with the ideas of family, respect and tradition. These ideas shape and mold the attitudes and beliefs that dictate the way Latinos internalize the information that comes into their communities.

religion / spirituality

For example, if an outreach worker in the middle of a presentation decides to assess the sexual activity of the group, this group might react negatively if it is not a homogeneous group. In some instances it is recommended to split the groups according to the topics to be discussed.

(information on this area does not appear in the video)

***family**

***women**

***splitting groups**

***religion**

***homosexuality (Jr.)(this is in the video)**

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Members of the Latino community as well as members of any other community in the United States are in constant danger of becoming infected with the Human Immunodeficiency Virus or the virus that causes AIDS. These risk factors augment with the barriers of language, illiteracy and lack of materials to address the specific populations.

There have been different kinds of information disseminated among the different Latino communities from sources with different degrees of reliability. Not all of the information is always culturally sensitive or even accurate. This is why it is so important to ensure the training of the people in charge of disseminating the information around the topics of cultural credibility and sensitivity.

**confidentiality*

**risk factors/drug abuse*

**other clips*

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Summary:

Let us summarize what we have heard in this video about the Latino community:

- Latinos come from very diverse ethnic and cultural backgrounds.
- Language and common ancestral culture unite these groups.
- Women are allowed to address sexual topics, but caution should be implemented when the groups are not homogeneous
- Culturally, most Latinos, have strict roles for males and females and crossing those guidelines is not seen positively.
- Groups should not be under estimated or over estimated
- The best way to find out credible information about a specific group is by obtaining information from a member of the same group
- Cultural groups must be empowered to do their own education

All these points are just some of the many things you might find out if you get close enough to the Latino community to gain cultural sensitivity. Please keep in mind that the best way to educate this community is by developing models and curriculums that include Latinos from the conception to the implementation.