

- *Swollen lymph glands (lumps) in the neck, armpit, or groin for several weeks*
- *Heavy, dry or persistent cough **NOT** related to smoking, a cold or the flu*
- *White blotches on the tongue or in the mouth*
- *Discolored bruises which may be flat or raised. They may be found anywhere on the body.*

THE REALITY:

BLACK PEOPLE GET AIDS TOO!

AIDS is no longer a gay white male's disease. In the United States, more than 25% of all people with AIDS are Black. Of all women with AIDS in the United States, 50% are Black. More than 60% of all babies born with AIDS are Black.

AIDS is a serious health condition caused by a virus. The virus causes the body to lose its natural defenses to fight off diseases. The body becomes very weak. To date, there is **NO CURE** for AIDS.

You can have the AIDS virus in your body and not know it. You can't tell if someone has AIDS by looking at them.

Changing sexual behaviors/attitudes and drug using habits will reduce the risk in Black AIDS cases.

AIDS does not care if you are:

- *Straight or Gay*
- *Black or White*
- *Male or Female*
- *Old or Young*
- *Doing Drugs or Not*



For more information on Educational Programs or services available or to make donations, contact:

AIDS EDUCATION UNIT

Bayview – Hunter's Point Foundation

6025 Third Street

San Francisco, CA 94124

(415) 822-7500



Concept by Bernie Wagner

COMMUNITY

AT

RISK

BLACK

The AIDS Education Unit, of the Bayview – Hunter's Point Foundation was created to serve the needs and concerns of the San Francisco Black Community. The time is now for ethnic communities to begin educating their own.

The Black community is in the middle of a horrible nightmare. Members are being attacked from all sides with a deadly disease called AIDS (Acquired Immunity Deficiency Syndrome).

At this time, the best defense against AIDS is Education. Education = Life.

WAYS YOU CAN'T GET AIDS

- *You can't get AIDS from toilet seats*
- *You can't get AIDS from water fountains*
- *You can't get AIDS from hugging someone with AIDS*
- *You can't get AIDS from sharing food or utensils*
- *You can't get AIDS on the bus or airplane*
- *You can't get AIDS being nice to someone with AIDS*

Located in the heart of the Bayview – Hunter's Point district, the AIDS Education Unit is a full service organization providing Education and Prevention primarily to the Black community.

We are dedicated to stopping the spread of AIDS among:

- Persons who share needles when shooting up
- Persons having unprotected sex.
- And others at risk for AIDS

If we do not make changes in our drug use and sexual behaviors by 1991, more than 100,000 people of color will have contracted AIDS.

THE AIDS EDUCATION UNIT OFFERS

- *AIDS Presentations*
- *In – Home AIDS Prevention Socials*
- *I.V. Drug Users Workshops*
- *Church/Street Outreach*
- *BAR Outreach*
- *Educational Materials (posters, buttons, etc...)*
- *Safe Sex Workshops*
- *Volunteer Program*

YOU CAN GET AIDS FROM:

- *Sharing unclean needles*
- *Having sex without condoms (rubbers)*
- *Exchanging body fluids: semen, vaginal fluids or blood*
- *An infected pregnant woman can pass the virus to her unborn baby*

It doesn't matter if you are straight, gay or swing either way, you should always wear a condom / rubber during sexual intercourse.

Remember: Everyone is responsible for his or her own body. The choice you make could save your life!

WARNING SIGNS OF AIDS

- *Sudden loss of weight over a period of time*
- *Long periods of diarrhea*
- *Persistent fever, chills, or night sweats*
- *Feelings of tiredness, or headaches*

OUTREACH TO BLACK GAY/BISEXUAL MEN
(black men who have sex with other men)
Phill Wilson, MA

As AIDS continues to cut its swath across the face of the nation, the need for innovative intervention strategies in the Black community becomes increasingly apparent. Very few such measures have been taken in the U.S. Although Blacks remain affected by AIDS at rates far greater than their percentages in society, still a host of cultural and socioeconomic factors continue to foil the externally developed methods of dealing with the epidemic. In short, what's being tried is not working, and new approaches are called for.

Black gay/bisexual (men who have sex with other men) men have shaped this nation in many ways. While their sexual identity may or may not have been known, their contributions to art, politics, sports, science, entertainment, religion, education and etc. have not gone unrecognized. In some instances, these men have been leaders and spokespersons.

Enter racism, enter sexism, enter homophobia, enter AIDS. Suddenly, these very same people, along with those who have openly addressed the issues impacting the gay/bisexual communities are compelled to join battle with forces which threaten our very survival.

The essential problem is one of personal efficacy and self-esteem. As Alvin Poussaint, the nation's pre-eminent Black psychiatrist, notes, the legacy of centuries of forced servitude, social segregation and color discrimination has had a physically and psychologically brutalizing effect on many (if not all) Black people and our psyches. This brutalization can result in a generalized sense of powerlessness, and in a broad based self-perpetuating cultural lack of self-esteem.

Evidence of this culturally reinforced lack of self-esteem can be found in the high rates of chemical addiction and substance abuse among Blacks. By the same token, we believe that high levels of denial and refusal to modify behavior in relation to the possibilities of HIV exposure and transmission is a further reflection of the cost being suffered by Blacks when we do not believe ourselves worthy of help or succor.

Black gay/bisexual men are especially victimized by this phenomenon. In addition to whatever race-linked low self-esteem afflicts us, homoerotically responsive Blacks are also victimized by homophobia. Black gay/bisexual are damaged in a multitude of ways. To make things more difficult, there has never been the independently organized homosexual rights movement which has truly included Black

homosexuals, such as we have seen among white homosexuals. This failure of organization and circumstance has left Black homosexuals without role models or a sense of our own proud history.

Bayard Rustin, for example, may be remembered as a famous civil rights activist, but few note or even know that he was gay. George Washington Carver may be remembered as a brilliant scientist, but his sexuality goes unremarked. Langston Hughes is regularly taught to Black children as a gifted poet; his sexuality is ignored. Similarly Billie Holliday, James Baldwin, Sojourner Truth, and on and on and on.

For the whole complex of reasons known and unknown, the truth remains simple and stark. In spite of the Kinsey data which suggests that the percentage of Black males who engage in homosexual activity may in fact be greater than the percentage for White males, indications are that homoerotically responsive Black men are less likely to identify themselves as homosexual or bisexual than their White counterparts. The closet grinds exceedingly fine.

Black researcher Julius Johnson notes that Black men who have sex with men are far more likely to enter into sexual pairings with women, to marry, and to father children both in and out of wedlock - while denying their homoeroticism. It may readily be seen that such men are direct conduits for the rapid spread of HIV among Black women and their progeny. These men are not likely to be reached by intervention efforts aimed primarily at Whites and/or White gays, precisely because they have few if any points of personal identification with such groups.

The result of this nexus of forces is a largely hidden population of homoerotically responsive Blacks, a population difficult to reach through extant AIDS prevention and education techniques. This group of men is likely to identify with the at-large Black community or in the context of the social environs of a Black Gay Community, and that is where they must be reached. Effective AIDS intervention work within this population must necessarily be multi-faceted, culturally sensitive, orientation specific and sexually explicit.

Included in the group Black Gay/Bisexual men are those Black males who engage in sexual relations with other men but who do not identify themselves as being "gay" or "homosexual." This group of men are often married with children. Their behavior may be "straight" during the week and "gay" on the weekend. Although precious little research has been done on this particular subject, the experience of some health educators suggests that high levels of bisexual behavior exist in the Black community. This fact is just beginning to

find acknowledgment. Men in this population are most likely to compartmentalize their sexuality due to the real and perceived degrees of homophobia amongst Blacks.

Furthermore, cultural expectations often dictate that a man denies, hides or hates his bisexual nature, and the result is high-risk behavior and low self-esteem. Closeted bisexuality among Black males increases the risk of HIV transmission to males and females because, by and large, bisexual Black men don't acknowledge their own inclusion in high-risk behavioral groups. It is important to note that even in this population, the male partners of these men are overwhelmingly self identified Gay/bisexual men. Therefore outreach to self identified black gay and bisexual men will have some impact on their sexual partners who do not self identify.

For Black men both in and out of the closet, traditional education and prevention programs don't work as effectively as those programs which have shown such success for white gay men. Often these educational models are only available in white gay settings or black non-gay settings to which many Black gay and bisexual men (both self identified and not) do not/cannot relate. Also the factor of denial within Black men at risk allows education directed towards to be rejected as irrelevant. Frequently, this has been true.

If we are to successfully reach Black Gay/Bisexual men, both in and out of the closet and self or non self identified; must develop multifaceted interventions which include the following elements.

First, it is essential that homoerotically responsive Blacks be endowed with a sense of empowerment and personal efficacy. Indeed, this is the center-piece of our approach.

Secondly, it is essential that the "veil of ignorance" be lifted, and that the Black community become educated about the critical roles Black gays and lesbians have played in the unfolding drama of gay life in America. Positive role models must be held forth.

Thirdly, it is essential that there be a highly visible inter-linkage with established Black organizations, institutions and media. One locus of any AIDS intervention program targeting Black Gay/Bisexual men must be the Black social club(s) or discos. These clubs/bars often attract homoerotically responsive Blacks from every walk of life from throughout the Metro area of the city. Typically, there is only one such major establishment in the entire metropolitan area, so it becomes a catch basin for the group we are trying to reach. This is true in most cities in the United

States. Many of the clientele of such establishments are who are "straight" during the week, but emerge from their closets on the week-ends. We want to reach them, of course, when they are available.

Forthly, the development of a highly visible gay and lesbian presence within the Black community. While this is a long-range goal, such a presence will greatly help to lift the veil of shame which currently blocks the penetration of AIDS information into the consciousness of those in need.

In conclusion, it is important to note that black gay/bisexual men represent the antithesis of a homogeneous group. Because of this, Outreach must be varied, consistent persistent.

**CULTURALLY-APPROPRIATE REFINEMENTS IN AIDS
PREVENTION AMONG AFRICAN AMERICANS**

Omowale Amuleru-Marshall, Ph.D., M.P.H.

Currently, questions of cultural significance are being raised regarding disease prevention and health promotion activities. There would seem to be no significant resistance to requiring that interventions for these purposes should be culturally-specific or culturally-sensitive. These two more commonly used terms are often interchanged with each other as if to imply that they refer, in general, to the same parameters. A much less frequently used term, culturally-appropriate, is occasionally used in ways that further obfuscate the other related concepts. I have begun, as a consequence, to argue for a clear distinction among these concepts. They can be shown to relate to quite different purposes. Before elaborating this argument, the notion of culture itself should be reconsidered.

Culture conventionally has been defined as the totality of social heritages...comprising inherited artifacts, goods, technical processes, ideas, habits, and values. Social organizations cannot be understood except as a part of culture (Hinsie and Campbell 1970). A definition of greater relevance to our purpose is offered by an African American scholar who asserts

that culture represents the vast structure of behaviors, ideas, attitudes, values, habits, beliefs, customs, language, rituals, ceremonies, and practices peculiar to a particular group of people, and that provides them with a general design for living and with patterns for interpreting reality (Nobles 1989).

Returning to a consideration of the terms: culturally-specific, culturally-sensitive, and culturally-appropriate, it would seem that they represent different notions. When the label "culturally-specific" is attached to a particular intervention, it merely might suggest that the intervention was designed for, or is targeted to, a particular cultural group. This fact alone will not qualify it as a culturally-sensitive model. Cultural-specificity would seem to be a necessary but insufficient condition for cultural-sensitivity.

A particular intervention designed for a particular cultural group can be said to be "culturally-sensitive" if it is also informed by an anthropological familiarity with the pertinent behaviors, ideas, attitudes, values, habits, beliefs, customs, etc., that is peculiar to that group. This idea is related to the concept of social validity promulgated by Baer (1984), which involves the acceptability of an intervention by those individuals most closely connected to it. Social validity methodology involves identifying all relevant persons and groups and asking them, through interviews and questionnaires, about the

acceptability of a particular intervention, including its means, results, and personnel. If the responses are negative, the intervention must be changed before being used again or the objectors must be educated and then reassessed. A number of programs, projects, materials, and interventions are being developed so that they satisfy this condition. However, when efforts, particularly those developed for oppressed persons, are limited to satisfying the condition of cultural sensitivity, they inevitably incorporate features of pathology, since oppression endemically breeds pathology.

Cultural sensitivity is, therefore, an insufficient, albeit necessary, requirement for programs that seek to be "culturally-appropriate". Culturally appropriate interventions would have to be designed prescriptively to heal the peculiar psychocultural traumas of the targeted group. According to Nobles (1984), as a moral demand system, culture has the power to compel behavior and the capacity to reinforce ideas and beliefs about human activity. Culturally-informed interventions must be conceptualized as responses to the "totality of social heritages" of a given group.

The African American case is the relevant illustration here. AIDS education and other disease prevention strategies targeting this population, if they are to be culturally-appropriate, should incorporate the peculiar social heritages of African Americans. In the face of our highly disproportionate vulnerability to AIDS-

related mortality and multiple other causes of mortality, the combination can truly be said to be race-threatening. No argument can be offered to dispute the fact that the historical event that brought us to this place of almost certain decimation was the holocaust of chattel slavery. Its impact on the continent of Africa and on her descendents was multifarious and grievous. One significant consequence of this holocaust was its direct attack on the cultural and spiritual integrity of enslaved Africans. This might be said to have been the beginning of the end. The progressive erosion of the cultural ethos of Africans is dialectically associated with the progressive encroachment of vulnerability to physical and social epidemics. As Diop (1986) explained, our condition might be understood as the final stage of a historical process that "...killed the being first spiritually and culturally, before seeking to destroy it physically."

The enslaved Africans, for example, were required to deny their name and nationality. Because the existential connection to Africa had to be severed, the symbolic adoption of slave names and the identity of a slave devoid of a sense of historicity was necessary. The cultivation of historical and psychocultural amnesia among Africans was a necessary process in the planned dehumanization of the African. Any people's humanity is seriously reduced by the loss of their memory. The denial of our inalienable human rights to self-control and self-determination,

which are of course diametrically inconsistent with enslavement, was another intended consequence of enslavement. The psychotic denial of the true and objective nature of reality also was inculcated so that the enslaved African would ultimately come to accept the immediate experience as unremarkable, civilized, uncriminal, and even christian. Ultimately, the African had to be completely ruptured from his or her Africanity--values, spirituality, and culture--for the enslavement enterprise to be successful.

It is a happy proclamation that the enslavement enterprise was never totally successful. Despite several generations born into the holocaust, Africans continued to resist consciously and unconsciously, through their collective unconscious or inadvertent cultural instincts. Chattel slavery did nonetheless foster, with varying degrees of success, alien self-knowledge, anti-self attitudes, and self-destructive practices (Akbar 1981; 1984). It is this complex of knowledge, attitudes, and behaviors that function as secondary enablers, but not causes, of our excessive risk of AIDS, drug abuse, violence, and related social epidemics. Consequently, the proposal is being made that efforts to repair the ongoing and recently escalating erosion of the cultural and spiritual underpinnings of African Americans will strengthen or rehabilitate our resiliency.

What is being prescribed is psychocultural reparation or the re-cultivation of own-group knowledge, own-group preference, and own-group maintenance among African-descended people. Strengthening these three areas corresponds to traditional activities that target outcomes in knowledge, attitudes, and practices. The development of the "Critical Cs," which represent psychocultural reparation: African American Consciousness, African American Commitment, and African American Conduct, will serve to inoculate African Americans. Our vulnerability is reduced by incremental improvements in the measure to which African and African American memory is restored, African identity is reclaimed, and a spiritually-based collective responsibility is cultivated. The African axiom: "I am because we are and because we are, therefore I am" (Mbiti 1971) offers a philosophical alternative to the normless individualism that frustrates our prevention efforts.

As presented earlier, if an intervention is unacceptable to the persons for whom it was intended, they should be educated and reassessed (Baer 1984). This requirement of social validity recognizes that occasionally, that which is culturally-appropriate may, in fact, be unacceptable to the targets of the intervention. Their preferences are conditioned by the pathology that was historically interwoven into their cultural fabric. An application of the principles of social marketing to prevention activities may enlighten this discussion. Social marketing

recognizes a dynamic relationship among the product, the price, the promotion, and the place of the intervention, revolving around the targeted consumer. The products being "sold" are culturally-appropriate ideas, values, and behaviors. The price is the degree of comfort associated with giving up previously comfortable ideas, values, and behaviors that will have to be changed to enhance resilience. The place refers to the channel through which the product reaches the consumer. It may be the mass media, a church, a fraternal organization, a community center, or a school. The place affects the price in that if the place is culturally comfortable, it could make other changes less unpleasant. Finally, promotion refers to the particular ways (content, intermediaries) in which the exchange is communicated.

Whether the intervention is designed for a primary, secondary, or tertiary point of impact in preventing the devastation of AIDS on African Americans, its effectiveness will be enhanced significantly, in the final analysis, by its augmentation with culturally-appropriate features. Primary prevention activities mounted to increase accurate information and awareness of the transmission of the human immunodeficiency virus (HIV) and to impact a reduction in high- and low-risk behavior should include other messages, as well. They should spell out the special relationship that is developing between HIV and Africans on the Continent, in the Caribbean, and here in the United States, juxtaposed against the relative disempowerment of

African persons with respect to the fundamental decisions and resource allocation affecting this epidemic. The role of this epidemic within our larger field of historical underdevelopment also should be emphasized. Finally, our people's historical will to survive in the face of unparalleled assaults on African life and civilization must be challenged as attempts are made to mobilize each one to teach one. Secondary prevention activities targeting known high-risk subgroups within the African American community with a view towards modifying high-risk behavior also can do no less. The restoration of the people's memory, reclamation of our identity, and redevelopment of our primarily Africentric culture with a consequent restoration of community and spirituality can only potentiate strategies to facilitate persons to act for life and not death. A commitment to the survival of the race must be molded. Finally, even tertiary interventions require this augmentation. The development of culturally-appropriate hospice care, provided within the cultural orbit of the African experience, is necessary to facilitate the terminally-ill to find meaning in their death through the experience of their group. Advocacy for services for African American persons with AIDS is the responsibility of the entire community. Its effectiveness will be hampered if the demands are not rationalized by the larger experience of the group that predisposed the vulnerability of the infected. African American Public Works Associations are merely front line or point persons; ultimately, their experience will be our experience unless the

entire community embraces these first casualties in but another battle of our people's war for self-determination and survival.

"I am because we are and because we are, therefore I am"

Mbiti (1970)



Gerald Lenoir, executive director of the Black Coalition on AIDS (L) and Bartholomew Casimir, gay activist, in the People of Color Mobilization Against AIDS March and Rally in Oakland April 1st.

AIDS: The black community fights back

*After years of frustration,
SF's black health activists are making
inroads against AIDS*

By Diana Carpenter-Madoshi

EIGHT YEARS into the AIDS epidemic, the myth that AIDS is a gay white male disease continues to thrive in San Francisco's black community, despite increasingly alarming statistics demonstrating the rapid spread of the disease among African Americans.

However, after years of frustration, denial and inaction, the black community is starting to fight back.

The sharp upsurge of AIDS cases among blacks over the past three years has spurred black health professionals, community leaders and even socially conservative ministers to mobilize at a new level. Suddenly, medical, educational and emotional support services are sprouting in a community where a few short years ago people infected with the AIDS virus or at risk of infection had almost nowhere to turn. It hasn't been easy: Black AIDS activists face a history of cultural denial, a deeply entrenched intolerance towards homosexuality among many religious leaders and a lack of financial support from the private charities and public agencies that have funded the fight against AIDS in other communities.

"We are in a crisis," Larry Saxon, former executive director of the East Bay AIDS Project, told the Bay Guardian. "This is the biggest challenge facing African Americans."

AIDS is affecting blacks in frighteningly disproportionate numbers. According to *California AIDS Update*, a state government publication, nearly a third of reported AIDS cases involve black men, seven out of ten babies born with the virus are black and 58 percent of the reported AIDS cases among women are black or Latino.

Since 1981, according to the San Francisco Department of Public Health, 481 blacks in San Francisco have become infected and by 1991, experts estimate that number will skyrocket to 1,140—plus an additional 1,276 in the rest of the Bay Area.

On a national level, blacks represent 12 percent of the total population, but constitute 26 percent of the AIDS cases. And in California, new cases of blacks with AIDS continue to outpace other groups.

"I was initially a disbeliever until I started listening to the figures," noted Dr. Patricia Evans, associate medical

director of the San Francisco Department of Public Health AIDS Office.

"But some of us in health care and other related fields came to realize that the disease was going to hit 'us' and it was not going to stay on the East Coast."

In 1986 there were no funds coming out of the San Francisco AIDS office specifically for ethnic minority communities, according to Evans. Black health professionals and other black professionals organized the Black Coalition on AIDS as an "alliance of organizations and individuals" working to fight the spread of AIDS in the black community.

THEY FACED formidable enemies in addition to the disease itself. "Issues of homophobia, poverty, racism, sexism and an overall attitude by black ministers that homosexuality is destroying the black family are some of the reasons why a lot of blacks are not actively involved in the fight against AIDS," explained Gerald Lenoir, executive director of the BCA.

Because, even in San Francisco, homosexuality is not as readily accepted in the black community as it is among whites, some gay blacks have a real fear of ostracism.

"Ethnic minorities do not like to be labeled," said Dr. Evans. "Take a man in jail [even if he has same-sex intercourse]—when he comes out of jail he will tell you 'I'm not gay or bi.'" (Many such men also have female partners—another way AIDS spreads so rapidly.)

That fear of ostracism gets in the way of gay blacks seeking medical care for AIDS. In addition, many blacks are skeptical or suspicious of any program connected with the government. The belief is widespread in the black community that HIV/AIDS is part of a government conspiracy to wipe out the black race.

Sala Udin, executive director of the Multicultural Resource Center, sees AIDS as a central part of an overall black health crisis: "Whether it is covert or overt, AIDS has become genocide to African Americans, spurred on by the availability of drugs in their communities."

Blacks with AIDS tend to wait until they are very sick before they seek treatment—and to die faster than gay white males.

Those who are integrated with the gay community will go to gay clinics. But in some existing AIDS programs, Saxon said, blacks face a lack of sensitivity to their culture. "Every black patient I sent to Shanti would leave," he noted. "Now, however, things there appear to be changing under the leadership of the new director, Eric Rofes."

For gay black males reluctant to be identified as gay, or for non-gay blacks at risk for HIV infection, there have been few facilities in their own community that specialize in AIDS-related illnesses.

In part this is a result of a more general shortage of health care in minority communities. "Racism," said Larry Saxon, "is the single most powerful reason this disease has crept into the black community the way it has," citing the Reagan administration's cutbacks in health and welfare programs.

Before 1986, there was only one program specifically targeted for blacks with AIDS—the Bayview Hunter's Point Foundation Program, under the directorship of Shirley Gross.

Now there are at least a half-dozen, including the AIDS Services programs at the Westside Mental Health Center and the Bayview Hunter's Point Foundation.

In addition to homophobia and the lack of accessible and affordable health services, the slow response of the influential black churches has delayed the black community's fight against AIDS. "The attitude has been: That's sin, we don't need to deal with it," explained James McCray, pastor of San Francisco's Jones United Methodist Church.

"The conservative wing of church officials have seen AIDS as a sexually transmitted disease passed on by a lifestyle not sanctioned by the church."

Liberals, on the other hand, says McCray, have seen it as just another outgrowth of their ministry to give support for the suffering without the moral judgment. McCray and his church members have been active in providing help and spiritual support for people with AIDS for two years.

Whatever their views, however, all churches are increasingly confronting the need for emotional support for blacks with HIV/AIDS, as families have become devastated by the illnesses or loss of a loved one with AIDS.

Recently, more black clergy seem to be responding. Reverend Cecil Williams of Glide Memorial Church has been meeting with African American ministers and asking them for more support and unity.

Williams was also instrumental in getting the ministers to participate, several months ago, in a candlelight march in support of help for people with AIDS.

INTRAVENOUS DRUG abuse, experts say, is the main reason for the sharp increase of AIDS among blacks in the last three years.

"The real challenge in the fight to stop or slow the spread of AIDS is in combating the substance abuse and needle use," said Florence Stroud, deputy director of public health.

"We got a very serious threat with the advent of 'crack' cocaine and other high-risk activities of IV drug users," said Rev. Williams. Crack cocaine has led to more heterosexual cases of AIDS in the black community. In 1986, intravenous drug use among blacks accounted for 8 percent of the AIDS cases. Now that has multiplied to a disturbing 18 percent.

The use of drugs and needles has become deadly especially for black women and their unborn children. A third of black women with AIDS become infected with the HIV virus through sexual intercourse with male IV users. Nearly half contract the virus by using contaminated needles or engaging in "survival sex" (a term coined by health professionals for sex exchanged for money or drugs).

"In the wake of the crack usage in the black community, the increase in the number of women who exchange sex for 'crack' is disturbing," said Pat Norman, director of the Youth Environmental Studies (Y.E.S.), a part of the MidCity Consortium to Combat AIDS. Whether crack or the new, highly addictive "ice" is smoked, snorted or taken intravenously, with less money coming in to hire outreach workers, the fight to stop or slow the spread of HIV/AIDS is becoming more grim, she said.

"The AIDS epidemic is the poverty program of the Reagan and Bush administration. We have to fight among ourselves for money for programs we know would be effective if we had more funding," Norman added.

In addition to Y.E.S., the state-funded MidCity Consortium to Combat AIDS is composed of five other San Francisco agencies: California Prostitutes Education Project (CAL-PEP), Central City Hospitality House, Haight Ashbury Free Medical Clinics, Larkin Street Youth Center and the Urban Health Study.

The heart of the MidCity Consortium is the Community Outreach Workers street-based program. It provides health education, training in AIDS-risk reduction, referrals and social support to intravenous drug users.

The Sexual Partners Integrity Resource Intervention Team also works through community health outreach workers, providing AIDS education to sexual partners of IV-drug users, services for sex workers, safe-sex workshops and more. In both of these programs, the outreach workers go out into the community to reach high-risk people who will not come to them.

At the Sept. 12th San Francisco Health Commission hearing, a heated

debate erupted among AIDS-related health providers (BCA, the MidCity Consortium, etc.) and black ministers, over the proposed needle-exchange program.

"It will give addicts ammunition to further destroy themselves, their families and their communities," Reverend Amos Brown of Third Baptist Church warned the Health Commission.

"But letting them [addicts] spread the HIV virus with contaminated needles, you might as well give them ammunition to wipe out the black community," countered Bartholomew Casimir, coordinator of AIDS outreach for the Black Coalition on AIDS.

In the end, AIDS activists like Brandy Moore of the BCA and the Raffi (Friend) Service Project, Patricia Evans and Shirley Gross persuaded the commission to approve the needle-exchange program by a vote of 5-1.

Moore pointed out, however, that a needle-exchange program is only one aspect of a total strategy to fight AIDS. The focus must be on prevention through education and on accessible treatment programs. Most AIDS-prevention programs, he said, have not had much success with blacks and other minorities because they often disseminate information in a way that is not culturally relevant and readily accessible.

"Blacks must be involved in their community. It must become a cultural fight against the HIV infection if any prevention and treatment program is to be successful," Moore concluded.

Despite the severity of the crisis, most black experts interviewed for this article said they remained optimistic. Sala Udin of the Multicultural Training Center observed, "There is an old African American saying: 'Behind every blessing is a curse and behind every curse is a blessing.'"

African American HIV/AIDS Resource List

BELOW IS A list (not necessarily complete) of agencies, groups and individuals in San Francisco who provide some form of information and/or care to African Americans living with HIV:

AIDS Education for Youth

Bernie Wagner
1950 Mission St., #6
565-9613

AIDS Education Unit
Bayview Hunters Point Foundation
Tanis Dasher, PHD
6025 Third St.
822-7500 (Education & Support)

AIDS Indigent Services
Michael Fremont-McGuire
55 Mason St.
476-6430

Center for Training
Elise Parker
2229 Lombard St.
931-9359

Edgewood Childcare Center
1801 Vicente
661-8560

Renetta Martin, Associate Director
UCSF-AIDS Health Project
1855 Folsom St., 6th floor
476-6430 (Multiservice)

MidCity Consortium
to Combat AIDS
Pat Norman, Program Director
507 Divisadero St.
922-6135 (Training & Education)

W.J. Brandy Moore, MPA
Office of the Speaker/Assembly
350 McAllister St.

Multicultural AIDS
Resource Center

Greg Harmon, Associate Director
1540 Market St. #320
861-2142
(Education Material & Prevention)

Multi-Cultural Inquiry & Research
Drs. Robert and Mindy Fulliove
6025 Third St.
822-40301

Multi-Cultural Training
Resource Center
Sala Udin, Executive Director
1540 Market St., #320
861-2142

Rosalyn Roddy
San Francisco AIDS Foundation
25 Van Ness Avenue, 3rd floor
864-4376 (Social Work)

Larry Saxon, AIDS Consultant
(Program and Education)
Saxon & Quinn Associates
470 Fillmore St. #2
861-7716

San Francisco Black Coalition
on AIDS
Gerald Lenoir, Executive Director
6025 Third St.
822-2223 553-8197

San Francisco City Clinic
356 7th St.
864-8100 (Testing)

San Francisco General Hospital
AIDS Health Service Project
Bldg. 1, room 202

Westside Community Mental
Health Program
WESTCAP Program
Teri Moore, Director
1153 Oak St.
431-9000

— D. C.-M

AIDS In San Francisco: New Controversies For The African American Community

By Ahimsa Porter Sumchai, M.D.

The San Francisco Department of Public Health's (DPH) *Status Report on AIDS in San Francisco for Fiscal Year 1987-88* details the current dimensions of the epidemic in San Francisco. The AIDS epidemic is termed "... the most serious health crisis ever faced by the City and County of San Francisco."

Inclusive of socioeconomic factors and for a multiplicity of reasons, being Black in America is a risk factor for development of the acquired immune deficiency syndrome. By January 31, 1988, 4,371 cases of AIDS had been reported to the DPH. Of this number only 285 (6.5 percent) were Black.

While this relatively small number of cases — at first — suggested the African American community was at low risk for the transmission of AIDS, careful scrutiny of the data revealed a disturbing pattern.

In San Francisco, a clear trend toward increasing numbers of African Americans diagnosed with AIDS was documented. In 1984, the total number of Blacks diagnosed with AIDS was 23 or 4.2 percent of the total population infected. In 1987, 103 cases of AIDS were reported among Blacks or eight percent of the total population infected.

Nationally, it is clear there is a disproportionate number of people from racial and ethnic minority groups with AIDS. These statistics differ sharply from the San Francisco experience. By February of 1988, 12,974 cases of AIDS had been reported among Blacks in the United States representing 25 percent of the total population of AIDS cases.

This frightening national trend has given San Francisco a unique protective opportunity. While it is clear that a growing number of AIDS cases arise from the African American community, with aggressive action and public education we are in the position to slow the progress of this epidemic among Blacks in this city.

The heart of the issue rests in understanding that the absolute number of people with AIDS is not a true reflection of the magnitude of this lethal epidemic.

Recall that the time from infection with the AIDS virus to manifestation of disease may be greater than five years. Thus we are looking backwards in time at the infection rate five years ago when we tally the number of AIDS cases today.

By the same token, to accurately gauge the numbers of AIDS cases we will be responsible for caring for five years in the future we must have a reliable sense of the numbers of individuals in the African American community infected with the AIDS virus today—with or without symptoms.

The most important numbers then are the numbers which indicated how many people each year become infected with the AIDS virus, not the absolute number of people with clinically evident disease. It is on the basis of

this information that the true threat of the AIDS epidemic to the Black community becomes most evident.

New studies indicate that for multiple reasons the rate of HIV infection may be ten times higher among Blacks compared to the general population. One study, recently cited by Donald Francis, M.D., head of the Mayor's Task Force on the HIV Epidemic, involved the testing of blood from all babies born in California.

This study is an indirect measure of the rate of infection by the AIDS virus of all women in the state. The rate of infection among the general population was one case per thousand. The rate of infection among Black women was one case per hundred!

There are currently multiple studies in progress to determine the rates of infection in high-risk neighborhoods. The Center for AIDS Prevention Studies (CAPS) has been established to coordinate research studies conducted primarily in minority communities that emphasize education in AIDS prevention.

CAPS is conducting a study of AIDS infection in 1,500 single adults, 20 to 45 years of age in the Western Addition, Mission and Bayview-Hunters Point areas of San Francisco.

Racism and segregation impact the Black community by producing a physical and psychological "quarantine" which contains transmission of infectious diseases within the community, conferring protection upon the outer society. The African American community must recognize that confinement of the spread of AIDS within the Black community is enhanced by the reality of racial segregation.

The role of public education in prevention of AIDS transmission cannot be overemphasized. AIDS prevention programs have been highly successful in the mostly-white gay community by bringing about a change in health-related attitudes and high-risk sexual behaviors.

It is clear that behaviors will change when AIDS is perceived as a true threat to the Black community, when AIDS is recognized as being avoidable and when the Black community collectively supports change in behaviors which lessen disease transmission.

Such a successful community program had dramatic impact on control of hypertension among Black men in Baltimore, Maryland.

The most complex issue we are now faced with is the potentially explosive spread of AIDS among IV drug users and its impact on the heterosexual community. IV drug users are perceived as a politically powerless group offering a much greater challenge to change in high-risk behavior than was seen among gay men.

The Black community is disproportionately represented among the IV drug-using population and the need for responsible leadership in addressing strategies to reduce the impact of the AIDS epidemic on Black

heterosexuals via this route of infection is mandated.

Responsible leadership is also needed in an effort to reduce AIDS hysteria. A recent public opinion poll revealed that one out of four people in the Bay Area fears AIDS. While this fear is effective in bringing about desirable changes in high risk behaviors it has also worked to instill negative attitudes among the general public and health care professionals about AIDS victims.

These attitudes, coupled with racist perceptions, may have destructive impact on Black AIDS victims from a community traditionally underserved by health care resources.

The final controversy we are left to contend with is the new direction of therapy for victims of asymptomatic AIDS infection called Early Intervention and Care. There is increasing evidence that two new drugs may prevent or delay the progression of disease among persons who have tested HIV positive, but have no symptoms of AIDS.

This preventive treatment may prolong life, decrease hospitalization and overall medical costs. The thrust for early intervention and care has formed the strongest justification for mass testing for HIV status.

For the first time, the potential for preventing the development of AIDS has prompted campaigns encouraging gay and bisexual men, IV drug users and their sexual partners to learn their HIV status.

While this hope for improved outcome is the "brightest star" on the horizon of AIDS research, it is estimated that there are approximately 30,000 people in San Francisco who are HIV positive and in need of testing, evaluation and early therapy.

The cost for providing care for all HIV-infected individuals in San Francisco will be in the range of \$100 million per year. The majority of the cost will go toward the purchase of drugs.

One such drug, AZT, or azidothymidine, has been shown by the National Institute of Allergy and Infectious Diseases trial to benefit persons infected with the AIDS virus who have not yet developed symptoms. AZT therapy is now estimated to cost each patient \$4,600 per year.

Another recommended drug which is believed to reduce the risk of pneumocystis carinii pneumonia is aerosolized pentamidine. Its use will cost \$1,200 per year.

The reality of delivering high-cost medications and expensive care to persons lacking health care insurance must be faced. The task of providing therapy to uncompliant intravenous drug users must be addressed.

Government subsidy for the burden of health care costs of AIDS victims is mandatory. For advocates of socialized medicine in the United States, the human and monetary costs of the AIDS epidemic factors may revolutionize the very foundation of our health care system.

'I have no illusions about the role of the mass media in mind control. I know that we will have to be more aggressive in calling for change.'

JOHN HENRIK CLARKE



In Our Image

Because what we see about ourselves often influences what we do about ourselves, the role of images and the question of how they control our minds are more important now, in our media-saturated society, than ever before. For the last 500 years, the history of African people throughout the world has been told through the slavery experience—only a short period in our life, considering that we are the oldest of the world's peoples.

There is a need now to look behind the slavery curtain in order to see what African people achieved as an independent people, before slavery. Because this independence existed for thousands of years before Europe itself existed, we should examine the far-reaching power of a European-created media over the minds of most of the world. Prior to the slave trade and European colonialism, which began in the fifteenth century, most of the peoples of the world had a concept of God shaped by their own culture and their own understanding of spirituality. They generally saw God, or any deity, as a figure resembling themselves. The expanding presence of the European made them consider not only a new God but a new image of God as well.

Because the Europeans did not have enough manpower to control the vast territories and populations they were taking over in Africa and Asia, they began to use

the media as a form of mind control, colonizing people around the world, just as they also colonized information about the world. Today the mass media includes every visual object that influences the mind—billboard advertisements, commercials and more, but especially movies and television.

Since we don't usually think of school textbooks as an aspect of the mass media, we don't fully understand that both Black and white children have a misconception about the role their respective peoples have played in the development of civilization.

Because of the exaggeration of the lives and achievements of Western heroes, especially Christopher Columbus, schoolchildren in general are of the opinion that most of the world's explorations and discoveries were made by Europeans. They also believe that Europeans went on discovery missions to other countries in order to spread Christianity and civilization. The contrary is true in many cases. In their expansion into Africa, Asia, the Caribbean islands and the Americas, the Europeans destroyed many old and well-functioning societies, usually for political or economic gain. The mass media has given us another picture of this phenomenon in history, and we have forgotten a recurring fact of history—that is, powerful people never have to prove anything to anyone. And by extension, powerful people never apologize

to powerless people for the actions they take in order to remain in power.

Because of the prevailing one-dimensional view of history that generally favors white people, who control the textbook industry, African-American students throughout the country began in the 1960's to call for Black-studies programs to correct some misconceptions about African people in world history. Twenty-one years ago, I and others with similar concerns established the African Heritage Studies Association. Its purpose was to bring together scholars of African descent who would dedicate themselves to the preservation, interpretation and academic presentation of the historical and cultural heritage of African peoples, both on the ancestral soil of Africa and in the diaspora in the Americas and throughout the world.

I have no illusions about the role of the mass media in mind control, and I know that we will have to be more aggressive in calling for change and that we must develop the personnel and the funds that will give us some control over at least part of the mass media. We can start by developing programs, textbooks and newspapers that cater to the African people of the world and will also be of interest to others. We need to seriously question and challenge the educational system that gives direction to our children. We also need to establish an independent educational system, starting in our homes.

We will have taken one giant step forward when we face this reality: Powerful people never teach powerless people how to take their power away from them. Education is one of the most sensitive arenas in the life of a people. Its role is to be honest and true: to tell a people where they have been and what they have been, where they are and what they are. Most important, though, the role of education is to tell a people where they still must go and what they still must be. ♦

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Acquired immunodeficiency syndrome in the black community: Focusing on education and the black male

REYNARD R. BOUKNIGHT, MD, PhD, LACLAIRE G. BOUKNIGHT, MD

Acquired immunodeficiency syndrome (AIDS) is destined to go down in history as one of the most devastating diseases ever to plague mankind. In addition to its impact on personal and public health, it has had profound national and worldwide effects economically, ethically, and politically. Based on past and present trends in epidemiology, the Centers for Disease Control (CDC) have predicted 270,000 cases by 1991, with 179,000 deaths. The economic impact could be astronomical since as much as \$147,000 is expended for the hospital care of each patient, excluding outpatient care, medication, and social costs.¹ In some cities, for single men between the ages of 24 and 44 years, AIDS is the leading cause of premature mortality as measured by years of potential life lost.² Already, in New York City, AIDS is the leading cause of death for males between the ages of 30 and 39 years, and the second leading cause of death for women aged 30–34 years.³ Despite these disturbing statistics, the impact on blacks is even more alarming since there are proportionately more AIDS cases in the black community and the mortality rate for blacks with AIDS is significantly higher as compared to whites.^{3,4} The black male stands as a key figure in the spread of the AIDS virus in the black community. It is imperative that he become a focus of AIDS education and that he play a major role in AIDS prevention.

BACKGROUND

The first cases of AIDS were reported by the CDC in 1981 in articles describing outbreaks of *Pneumocystis carinii* pneumonia and Kaposi sarcoma in homosexual men from New York City and California.^{5,6} Since that time, the causative agent has been identified as the human immunodeficiency virus (HIV), formerly referred to as the human T-lymphotropic virus type III (HTLV-III), the lymphadenopathy-associated virus (LAV), and the AIDS-associated retrovirus (ARV).⁷ Supportive evidence indicates that HIV may have originated in Africa and that it may be related to the simian immunodeficiency virus (SIV).^{8–13}

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HIV relentlessly disarms the immune system by attacking and destroying a patient's helper T-lymphocytes. AIDS represents the end stage of infection with this virus, but asymptomatic carriers and patients with AIDS-related complex (ARC) account for a much higher proportion of HIV disease. For every patient with AIDS, there are probably six or seven with ARC. For every patient with ARC, there are probably ten asymptomatic carriers. The virus is thought to be latent in this latter group. They are considered infected for life and are quite capable of transmitting the virus to others. Approximately 1.5 million Americans are currently infected with HIV, and 20–30% of them will develop AIDS over the next five to seven years.

TRANSMISSION

Transmission of the AIDS virus occurs mainly through sexual contact, blood transfusion, perinatal transfer, sharing needles, receiving infected semen, and exchange of other body fluids. The high-risk groups most likely to contract and transmit the virus include male homosexuals and bisexuals, intravenous (IV) drug abusers, hemophiliacs, children born to seropositive mothers, and sexual partners of those at risk for the disease. Casual contact with an infected person, including handshaking and sharing drinking glasses, toilets, or clothing, does not transmit the AIDS virus.^{14,15} There is no documented evidence that insect vectors such as lice, ticks, and mosquitoes, or vaccines such as hepatitis B, are involved in the transmission of HIV.

AIDS IN BLACKS

Since AIDS was initially discovered in homosexual men, who represent the major risk group, there is a general perception that AIDS is nearly exclusively a "gay men's disease" and, more specifically, a "gay white men's disease."¹⁶ This is certainly a misleading perception which requires prompt attention and correction since AIDS has disproportionately affected blacks.^{4,17} Although blacks represent only 12% of the American population, they account for approximately 25% of the adult AIDS cases reported (Table I). It is estimated that 1–1.4% of the black population is infected with the virus compared to 0.3–0.5% of whites.¹⁶ Using the Public Health Services model for future projections, it is estimated that by 1991 there

TABLE I. Comparative Analysis of Human Immunodeficiency Virus Infection by Race

	Blacks	Whites*
US population	12.0%	88.0%
AIDS patients—total ⁴	25.0%	75.0%
AIDS patients—homosexual/bisexual ¹⁶	46.3%	88.9%
AIDS patients—IV drug abusers ¹⁶	35.4%	5.2%
HIV positive recruits ²¹	0.39%	0.09%
Estimated HIV prevalence ¹⁶	1.0–1.4%	0.3–0.5%
AIDS life expectancy [†]	18 wk	24 mo

* Includes all non-blacks.

† From CDC.

will be 67,500 blacks with AIDS, with 45,000 deaths.¹⁸ In Michigan alone, blacks represent 13% of the population but 41% of the cases of AIDS.¹⁹ In addition, 36.8% of all AIDS patients in Michigan are black males, 69% of all women with AIDS in Michigan are black, and 80% of the infants and children with AIDS in Michigan are black (personal communication, Michigan Department of Public Health, December, 1987). The impact on minority children is even more striking in New York City, where 97% of children with AIDS are black or Hispanic.²⁰ AIDS testing of military recruits reveals a higher percentage of seropositivity among black recruits when compared to their white counterparts. A recent study showed that white recruits had an HIV seropositive rate of 0.9 per 1,000, whereas black recruits had over four times this rate, at a seropositivity of 3.9 per 1,000.²¹

HIV TRANSMISSION IN BLACKS

Epidemiologic patterns of AIDS transmission in blacks differ from patterns observed in whites. Whereas whites experience the spread of this disease primarily through male homosexual contact, the black community is affected more by spread through intravenous drug use and heterosexual contact, and this poses greater levels of risk to the general black heterosexual population.^{4,17,22} Black homosexual and bisexual men account for 46.3% of all cases in blacks and intravenous drug users account for 35.4%.¹⁶ In contrast, among whites, 88.9% of cases are among homosexual or bisexual men and only 5.2% are among heterosexual IV drug users.¹⁶

BLACK IV DRUG ABUSERS AND AIDS

The disproportionate incidence of AIDS in the black community is at least in part related to heavy intravenous drug use in densely populated urban areas. More than 750,000 IV drug abusers are at risk for this infection and 200,000 are already infected.²³ The majority of women with AIDS are IV drug abusers between the ages of 13 and 39 and are in their peak childbearing years. Their newborn children have a 50–60% chance of being infected with the AIDS virus.^{23,24} In the State of Michigan, an increasing proportion of AIDS cases in recent years are directly or indirectly due to IV drug abuse (Fig 1). According to the Michigan Department of Public Health, 71% of Detroit's newly reported cases in the first two months of 1988 were drug related.

The cocaine epidemic in Detroit and the rest of Wayne County has a significant impact on the risk of AIDS to

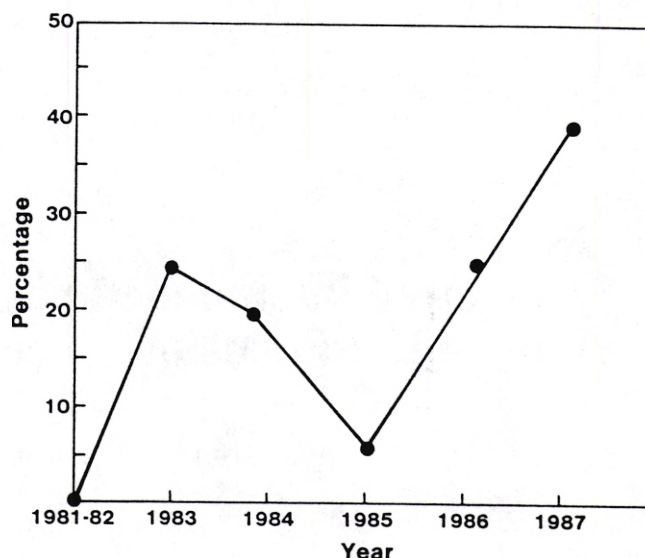


FIGURE 1. Percentage of new IV drug abuse-associated cases of AIDS per year—Michigan.

blacks in Michigan because cocaine is frequently used intravenously alone or in combination with heroin (speedballing) (Fig 2). Statewide, two out of three people admitted for cocaine abuse are black and 85% of statewide "crack" admissions ("crack" is the smokable form of cocaine) are black.²⁵

Heroin has a significant impact on the Michigan black urban community, since in Detroit and Wayne County 70% of patients admitted for heroin treatment are black and 67% are black males. Other intravenous drugs contributing to the spread of AIDS in the black community include Percodan, morphine, and Demerol™. The prison population is another site of IV drug use among black males. Drug paraphernalia such as syringes are in limited supply, encouraging the sharing of needles which facilitates the spread of the AIDS virus. Obviously, prison officials are reluctant to supply sterile equipment for illegal drug use. The transmission of HIV among IV drug abus-

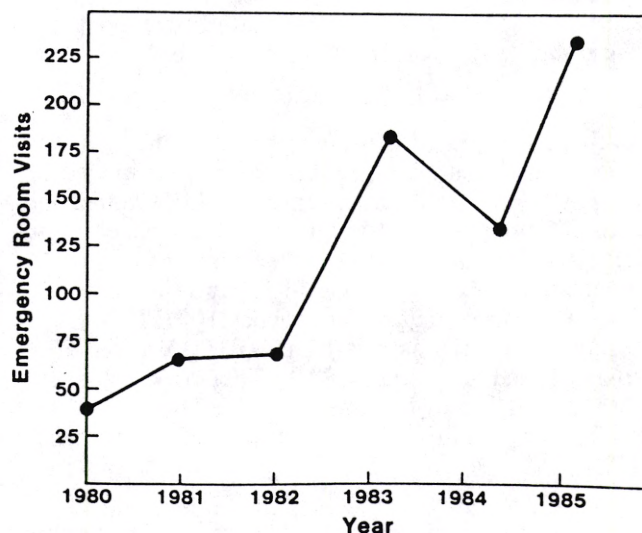


FIGURE 2. Use of cocaine and heroin in combination—Detroit (from Michigan Department of Public Health).

ers is related directly to the frequency of injections, the sharing of equipment, and the length of drug abuse.²³

IMMIGRANTS

Another factor contributing to the distribution of AIDS in blacks involves AIDS in people from foreign countries, since this group comprises primarily blacks from Haiti and Central Africa.²⁶ Many are economically disadvantaged immigrants residing in New York or Miami, who either lack private health insurance or financial resources or are ineligible for government subsidized medical services.^{26,27}

PRISONERS

It is well known and recognized that blacks make up a higher proportion of the prison population when the percentage of black prisoners is compared to the percentage of blacks in the general population. Although prison administrators try their best to provide supervision, there is still considerable homosexual behavior and intravenous drug use within the prison walls. Some of the homosexual behavior is forced and involuntary. Thus, prisoners represent another potential risk group and again blacks are potentially overrepresented with regard to HIV infections.²⁸

HEALTH CARE COSTS

The rapidly escalating number of AIDS cases is putting a severe strain on many already floundering medical facilities, particularly public hospitals in urban areas. In New York's Bellevue Hospital, AIDS patients occupy over one third of the internal medicine beds.²⁹ Although hospitals treating AIDS patients have high occupancy rates, they are losing as much as 50-70 cents on each expense dollar.³⁰ It is expensive to care for AIDS patients and reimbursement does not cover all of the large daily costs. Public hospitals in urban areas are financially drained because of the large percentage of AIDS patients who are IV drug abusers. White homosexuals with AIDS tend to have a higher socioeconomic status than the general population and are more likely to have health insurance.²⁹ In contrast, the IV drug abuser is more likely to be unemployed and without health insurance. Of all cocaine addicts admitted to Wayne County hospitals, 77% were unemployed. The patients with IV drug abuse-associated AIDS are also more expensive to care for because they do not seek care until the latter stages of the disease, have more infections, and have a poorer prognosis.¹⁶

Many patients who do not have private insurance are covered by Medicaid. In San Francisco, 25-30% of those dying with AIDS are on Medicaid, while 65% of New York's AIDS patients are on Medicaid. Due to many socioeconomic factors, blacks are overrepresented as Medicaid recipients. Sixty-five percent of AIDS patients receiving Medicaid in Michigan are black. The lifetime cost of treating one AIDS patient in Michigan is approximately \$29,000. Nationally, it is predicted that the cost to Medicaid for AIDS care will be \$1 billion in 1991.²⁹ As time goes on, Medicaid, which covers approximately 23% of AIDS expenditures at this time, will bear more and more of the brunt of the cost of AIDS. Private insurers are opting to drop AIDS patients from their rolls. Ninety-one percent of commercial insurers feel that people testing

positive for HIV are uninsurable, and there is evidence that the proportion of AIDS patients with private insurance is declining.³⁰ Medicare has not been an option for most AIDS patients because the waiting period for disability coverage is two years, and most AIDS patients do not survive that long.

PREVENTING AIDS IN THE BLACK COMMUNITY

The devastating impact of the AIDS epidemic is aggravated by the fact that this disease is incurable, and given enough time is probably uniformly fatal. The AIDS virus integrates its genetic code into the victim's cellular make-up and forces the patient's own cells to produce the products destined to destroy the host.³¹ The virus can lay dormant in the unsuspecting host for years and be insidiously spread to others without either person's knowledge. Azidothymidine (AZT) has been approved by the Food and Drug Administration (FDA) for use as a treatment of selected patients, but AZT is highly toxic, has limited use, and is not a cure for AIDS.³² The first clinical trials for a vaccine (VaxSyn HIV-1) against HIV will begin soon, but final stages of testing of large populations will not begin until the 1990s.³³ Thus, the most promising means of preventing the further spread of AIDS in the black community is education followed by responsible behavior.

Black men must begin to act more responsibly with regard to their sexuality and intravenous drug use. Those who are bisexual should inform their wives and any other prospective partners—male or female—about former and current sexual liaisons. They should practice "safe sex," including abstinence and use of condoms, and should consider voluntary HIV testing.³⁴ When positive, they should be vigilant to assure that they are not responsible for any additional HIV transmission. Heterosexual male IV drug abusers must likewise become more honest, concerned, and responsible towards their sexual partners. Many women who become infected with HIV are totally unaware that they are intimately involved with a bisexual male or an intravenous drug abuser. IV drug abusers should likewise consider voluntary testing and practice safe sex. They should avoid needle sharing, sterilize their equipment, and enroll in treatment programs to break the vicious hold of drug addiction. It appears that prostitutes are becoming a greater source of AIDS virus transmission, and this represents another area which will require more responsible behavior on the part of the black male if an effective war is to be waged against the spread of AIDS in the black community.³⁵ Black women and the black community at large should encourage, if not insist on, more credible behavior from the black man. This can be done by encouraging voluntary AIDS testing for known homosexual and bisexual men and known IV drug abusers, informal monitoring of those who are seropositive to encourage them to practice safe sex, and providing educational opportunities using physicians and other resources for a better understanding of AIDS and its prevention.³⁶ It is important to recognize that current education and prevention programs may be less effective in reaching minority populations, since they are not specifically designed for these groups.¹⁶

Targeted programs for AIDS prevention are needed for black men who engage in homosexual activity, and for

blacks of either sex who engage in other high-risk behavior, including intravenous drug abuse. This identifies a central role for minority professional and community organizations in providing education about AIDS and its prevention in the black community. More health education and risk reduction projects are needed to actively involve black communities to accomplish overall community AIDS risk reduction activities. The key to the success of these programs will be the response of the black male.

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Issues in the Prevention of AIDS Among Black and Hispanic Men

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ABSTRACT: *Ethnic minority men, particularly Blacks and Hispanics, make up a significant proportion of all AIDS cases in the United States, with these cases linked primarily to homosexual or bisexual behavior and intravenous (IV) drug use. Difficulties in developing successful prevention strategies include (a) limited data on the prevalence of AIDS risk behaviors among minorities, (b) limited information on successful community interventions for minority populations, and (c) problems in using social networks for AIDS prevention. Suggestions are made to include culturally appropriate information in developing communication messages and to consider culture-specific values, norms, attitudes, and expectations in designing community interventions.*

Typically, prevention research on acquired immunodeficiency syndrome (AIDS) in the United States has focused on White¹ homosexual and bisexual men. Recently, however, there has been evidence that ethnic minorities represent a sizeable percentage (40%) of the cases of AIDS: Twenty-four percent of all AIDS cases are among Blacks and 14% among Hispanics (Centers for Disease Control [CDC], 1986a). In fact, relative to their proportion of the total population, Blacks and Hispanics have an incidence of AIDS two or three times higher than Whites for homosexual and bisexual males and over 20 times higher than Whites for heterosexual males (Bakeman, Lumb, Jackson, & Smith, 1986; Bakeman, Lumb, & Smith, 1986; Bakeman, McCray, Lumb, Jackson, & Whitley, 1987; CDC, 1986a; Hopkins, 1987; Rogers & Williams, 1987; Selik, Castro, & Pappaioanou, 1988).

Unlike AIDS cases among Whites, nearly half of the cases of AIDS among Blacks and Hispanics have occurred among heterosexual intravenous (IV) drug users or their sexual partners (Bakeman et al., 1987; Brown, Evans, Murphy, & Primm, 1986; Des Jarlais & Friedman, 1987; Ginsberg, 1984; Peterson & Bakeman, in press). This high frequency of AIDS cases among minority heterosexual IV drug users is further responsible for most of the AIDS cases among Black and Hispanic women (over 70%) and children (over 80%; Guinan & Hardy, 1987). There are also differences between Whites and minorities in the rates of infection with the human immunodeficiency virus (HIV; CDC, 1986b). Data from the Department of Defense antibody tests of military recruits showed that Blacks and Hispanics were three times more likely than Whites to be seropositive.

The high incidence of AIDS among Blacks and Hispanics requires that approaches be developed to prevent further HIV infection in these populations. Those planning interventions need to consider the behaviors and attitudes in these minority groups that affect the success of AIDS prevention campaigns. These issues are discussed for the two groups of minority men who are at highest risk for AIDS: homosexuals or bisexuals and IV drug users.

Issues for Minority Gay Men

High Risk Sexual Behavior

Previous research suggests that the AIDS virus is primarily transmitted through unprotected sexual activity (Echenberg, Rutherford, O'Malley, & Bodecker, 1985; Goedert et al., 1984; Jaffe et al., 1983; Marmor et al., 1984) and through the sharing of intravenous drug equipment (Des Jarlais, Friedman, & Hopkins, 1985; Friedland et al., 1986; Marmor et al., 1984). Because the sexual behaviors of minority gay men have been rarely studied, it is difficult to determine the frequency with which these men engage in high-risk sexual behaviors. Bell and Weinberg (1978) included only a small sample of Black men ($N = 111$) in their study of homosexual men in San Francisco, and many cohort studies of homosexual men do not yield representative samples of minority men due to sampling problems (e.g., Samuel & Winkelstein, 1987). Nevertheless, the Bell and Weinberg study failed to reveal differences between Whites and Blacks in reports of fellatio as the most frequently performed sexual activity. However, whereas hand-genital contact was the second most frequently reported activity of White gay men, Black gay men reported anal intercourse as their second most preferred activity. More Black (90%) than White (78%) gay men had experienced receptive anal intercourse, and over 75% of Black gay men had experienced more than 250 partners. Although no data

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¹ The word *White* is used here to denote Whites not of Hispanic heritage. The word *Hispanic* refers to those individuals who trace their background to Spain or Latin America, independent of their race.

on the sexual practices of Hispanic homosexual men are available, Carrier (1985) has suggested that anal intercourse is the most preferred homosexual practice between Mexican males.

AIDS Attitudes and Beliefs

Some minority gay men may erroneously believe that anal intercourse is safe if they are the active rather than receptive partner or that high-risk sexual activities are safe if they only engage in those activities with minority rather than White men. Therefore, researchers will need to consider how the subjective perceptions of minority homosexual men are associated with the costs and benefits of participating in certain sexual activities. These perceptions may be significant determinants of their involvement in practices that pose either high or low risks for HIV infection (Catania, Kegeles, & Coates, 1988; Fishbein & Ajzen, 1975; Triandis, 1972). Presumably, gay men are less likely to exchange high-risk behaviors for less risky activities if the risky behaviors are perceived as more pleasurable. Consistent with this assumption, some data indicate that minority men dislike using condoms because they are felt to be uncomfortable and inconvenient (Carrier, in press; Marin & Marin, 1987).

Whether minority gay men consider themselves at risk for AIDS or not, they are still unlikely to engage in safe sexual activities unless they believe they are capable of making the necessary behavioral changes to reduce their risk for AIDS. In this view of self-efficacy (Bandura, 1977), for homosexual men to engage in AIDS prevention they must believe that they are able to perform activities that reduce their risk of exposure to the AIDS virus. Stated differently, if minority gay men do not feel that they have the ability to follow the recommended safe sex guidelines, then they will probably ignore those recommendations and continue with high-risk behaviors. Knowledge of AIDS and perceptions of susceptibility to AIDS are insufficient to predict adoption of health behaviors unless gay men believe that they are able to perform those behaviors (Catania et al., 1988).

AIDS Information

In the absence of a vaccine or a cure for AIDS, reduction or elimination of high-risk behaviors constitutes the only effective strategy for prevention of this disease. Although not sufficient, AIDS knowledge or information is necessary to assist minority gay men in changing their high risk behaviors. However, a Black community survey in Detroit found that Black gay men were less informed about the AIDS epidemic than Black IV drug users and were unable to correctly identify the modes of transmission of HIV, a result that may partially explain why most of the respondents were not concerned about the possibility of infection or of an AIDS diagnosis (Williams, 1986).

Beyond this study, there is a lack of research on the amount of information that Black and Hispanic homosexual men have regarding AIDS. The supplemental questions on AIDS in the National Health Interview Sur-

vey (HIS) did not include a Hispanic identifier until the May 1988 wave of the survey, and the internal validity of the survey responses by Hispanics is questionable because the interview schedule is available only in English. HIS data on Blacks are available from the National Center for Health Statistics; preliminary analyses of these surveys indicate that Blacks consistently report lower levels of information about AIDS and greater proportions of erroneous knowledge regarding HIV transmission than do Whites (Dawson & Thornberry, 1988).

Research is needed on the health-belief schemata of minority men as seen in their perceptions of risk for AIDS (e.g., the beliefs that being the active or insertive partner is a safe activity in anal sexual intercourse and that non-White gay men are safe from AIDS if they avoid sex with White gay men). Because of these beliefs, many minority men who engage in same-sex activities may reject or discount AIDS prevention messages and continue to deny that their sexual behavior puts them at risk for AIDS or HIV infection. These beliefs seem particularly important to effectively influence behavior change among bisexual males.

Cultural differences, prejudice, and racism isolate many ethnic minority men from the usual sources of information available to White gay men (e.g., gay newspapers, AIDS brochures, and many gay bars and clubs). Furthermore, some cultures have been found to have strong antihomosexual attitudes that may prevent many minority men from either receiving AIDS information or from accepting it if received (Carrier, 1976). For example, posters that informed Dominican men about the use of condoms were ineffective because men were reluctant to be seen reading them in public (A. Moya, personal communication, November 1987). For this reason, verbal communication may be more useful in reaching minority gay men who have not publicly disclosed their sexual orientation and nongay minority men who have sex with other men in anonymous contexts (e.g., public restrooms, parks, adult bookstores, steam baths). Street outreach campaigns could be used by employing minority men who are knowledgeable about AIDS risk reduction and who are familiar with the sociosexual contexts of Blacks and Hispanics.

The difficulty in reaching bisexual or heterosexual minority men involved in high-risk behaviors with other men suggests the need to reach these men through community-wide information campaigns and through relatives and friends (B. V. Marin, G. Marin, & Juarez, 1988). For example, surveys of media use by Hispanics have found that radio may be more important than television and that Spanish-language newspapers are less frequently read than expected (e.g., Sabogal, Otero-Sabogal, Marin, Marin, & Perez-Stable, 1986; Shoemaker, Reese, & Danielson, 1985). If written communications are used (e.g., pamphlets, brochures), health information messages will need to be available in both English and non-English languages, and the latter should not be translated literally from materials written in English. Communications must use clear, simple messages with high credibility and avoid

confusing phrases that are easily misunderstood. The need to consider these language problems is made salient by recent evidence that Hispanic males did not know the meaning of or referents for the Spanish equivalents of the English terms for anal or oral sexual relations and that the term "active sexual life" was misperceived as only including extramarital and risky sexual practices (B. V. Marin et al., 1988). Furthermore, communications should be written at or below the fifth-grade reading level to avoid exceeding the educational attainment of many low income minority men and should be in "broadcast" Spanish to avoid regional variations in language usage (B. V. Marin et al., 1988).

Variable Sexual Orientation

Cultural socialization and limited development of a minority gay community may influence minority gay men to be more variable in their sexual orientation identity than White gay men. Many minority men may have extensive homosexual experiences without affecting their heterosexual sexual orientation. This assumption seems supported by the percentage of bisexual AIDS cases reported to the CDC. Of the homosexual/bisexual AIDS cases, the percentage of cases that are bisexual are 31% for Blacks, 20% for Hispanics, and 13% for Whites (Bakeman et al., 1987). Several authors (Blumstein & Schwartz, 1977; Humphreys, 1970; Reiss, 1961) have suggested that many men who have sex with other men may not label themselves as homosexual depending upon the meaning of or reasons for the sexual behavior. An individual may engage in bisexual behavior sequentially, ranging from homosexual to heterosexual involvement at different time periods, or contemporaneously, involving both male and female sexual partners during relatively close periods in time (Paul, 1984). Similarly, a person may engage in sexual activity for recreational reasons related to the satisfaction of physical pleasure or for situational reasons associated with economic motivations (e.g., male prostitution; DeLamater, 1981). Furthermore, some men protect themselves from the inference of homosexual identity, despite their homosexual activity, by exclusively engaging in either anonymous sex (Humphreys, 1970) or in only those homosexual activities that some men consider to be masculine roles (i.e., the insertor role in oral and anal sex; Carrier, 1985; Parker, 1985).

Lack of Social Networks

Since the transmission patterns of HIV were identified, community education has been the most effective strategy to prevent the continued spread of the AIDS virus. Until recently, however, few public information campaigns had been developed for minority homosexual and bisexual men. Community-based interventions among White gay men have successfully demonstrated that if they obtain the appropriate information and social skills through their social networks, gay men can develop the type of social norms that support individual and community behavior change (Communication Technologies, 1987; Jacobs, Ross, Walker, & Stockdale, 1983; Joseph et al., 1987;

Namir, Wolcott, Fawzy, & Alumbaugh, 1987; Weisman, Worden, & Sorbel, 1980).

Individual sexual behavior is influenced by community norms and consequently requires changes in social agreements about normative behaviors among members of the gay population. This sociological strategy requires that enough gay or bisexual males at risk for HIV transmission change their behavior to warrant unsafe sexual and drug-related activities being viewed as unacceptable. If this argument is correct, gay men who experience these changes in community norms should be more likely to endorse less risky sexual practices and drug behaviors.

Although such community interventions have been employed with White gay men, there have been few designed specifically for minority gay or bisexual men. This is a difficult process because of the lack of formal gay organizations in many minority communities, particularly outside urban metropolitan areas. Even in those cities with such social networks, interventions designed for gay men will only be useful for minority males who identify as homosexual. However, it is unlikely that minority bisexual or heterosexual men, at risk for HIV infection because they have sex with other men, can be effectively influenced through the same interventions developed for high-risk White gay men. Community interventions will have to be developed that include group-specific values, attitudes, norms, and expectations. For example, it is doubtful that Hispanics will be willing to attend small discussion groups on AIDS prevention because important cultural values deter individuals from sharing personal problems with nonfamily members (Sabogal, Marin, Otero-Sabogal, Marin, & Perez-Stable, 1987).

Issues for Minority Male IV Drug Users

Sharing IV Needles and Syringes

The second highest percentage of AIDS cases is reported among IV drug users, nearly all of whom are heterosexual and 80% of whom are Black or Hispanic (Des Jarlais & Friedman, 1987). IV drug use results in HIV infection primarily through sharing the equipment ("works") used in drug injections (Des Jarlais et al., 1985; Friedman, Des Jarlais, & Sotharan, 1986; Redfield et al., 1985; Weiss et al., 1985). Black and Hispanic IV drug users have been reported to be more likely to engage in sharing their IV drug equipment than are their White counterparts (Des Jarlais et al., 1985). Furthermore, some Hispanics in the United States, especially recent immigrants, reuse needles and syringes for vitamin and medication injections and may share their equipment with neighbors and friends.

Due to legal restrictions on the supply of sterile needles and syringes, IV drug users experience difficulty in obtaining new needles and syringes, and minorities may be even less able to obtain works because of costs (Drucker, 1986; Friedland et al., 1986; Gorush & Butler, 1976; Marmor, Des Jarlais, Friedman, Lyden, & El-Sadr, 1984). This economic disadvantage may explain the

shared use of rented works in "shooting galleries" by minority IV drug users. Some IV drug users also engage in shared IV drug use as a means of social bonding with "running partners" or individuals who cooperate with each other to obtain drugs or money to purchase drugs (Des Jarlais, Friedman, & Strug, 1986).

Although AIDS prevention campaigns may not effectively convince most IV drug users to discontinue injecting drugs, it is possible that many will eliminate or reduce their practice of sharing unsterile drug equipment. In fact, prevention of HIV transmission does not require ending drug injections but only injections involving contaminated needles and syringes. This is an important point because of the physical, psychological, and social difficulty of quitting drug use (Des Jarlais & Friedman, 1987). There is documentation that minority IV drug users will change their needle-sharing activities to reduce their risks for HIV infection (Des Jarlais & Hopkins, 1985; Friedman et al., 1987; Selwyn, Cox, Feiner, Lipschutz, & Cohen, 1985).

There is a need to develop appropriate AIDS prevention and education programs in drug treatment clinics in minority communities (Des Jarlais et al., 1985; Peterson & Bakeman, in press). These community-based AIDS prevention programs would educate IV drug users about their risks of AIDS either before they were infected or before they infected their sexual partners. These programs would also allow greater opportunity to teach needle users the specific techniques of risk reduction, such as methods for cleaning drug equipment. Future programs should include ethnic minority staff who would be more accepted by minority addicts because of their knowledge of the minority culture values, particularly social scripts related to respect and positive social relations (Triandis, Marin, Lisansky, & Betancourt, 1984). In this context, IV drug users are more likely to develop the self-efficacy to adopt less risky drug behaviors if they obtain the social skills and social support to change. Physicians and other health care providers, such as drug abuse treatment staff, can be important sources of health information in minority communities; however, many of these health professionals may be less competent in providing sexual counseling to their patients and clients (Lewis & Freeman, 1987). Therefore, clinic staff should receive in-service training to instruct them about counseling and making referrals where appropriate (Des Jarlais & Friedman, 1987). Also, attention should be devoted to misperceptions of AIDS as a gay White male disease, as well as to attitudes that preclude adoption of safe-sex practices.

Because IV drug users not in treatment are estimated to outnumber those in treatment four to one, prevention research and education is critically needed outside of drug treatment programs. Mass media campaigns (as suggested for gay men) and street outreach programs may be useful in contacting this substantially larger population of high-risk addicts. This latter approach emphasizes face-to-face communication to provide AIDS health education (Jackson & Rotkiewicz, 1987). This strategy avoids the use of incriminating written documents and allows for more

spontaneity in interpersonal interaction with the recipient of the health information (Des Jarlais & Friedman, 1987). Printed educational materials could then emphasize photographic presentation of methods to sterilize drug equipment.

HIV Transmission to Sexual Partners

IV drug use among minority men directly accounts for a large number of minority female cases of AIDS as a result of sexual contact, as well as the high prevalence of minority pediatric AIDS cases through perinatal transmission (Lapointe, Michaud, Pekovic, Chausseau, & DuPuy, 1986). Sexual transmission is implicated because of unprotected sexual activity with an HIV-infected male partner. Because many male IV drug users have had primary sexual relationships with women who do not engage in IV drug use (Des Jarlais & Friedman, 1987), female partners of IV drug users are likely to be part of a secondary epidemic of heterosexually transmitted AIDS cases, especially among Blacks and Hispanics.

Many sexual partners of IV drug users may not realize that they are at risk for HIV infection. Even if IV drug users are seropositive, some data indicate that they usually are not prepared to disclose their serostatus to their partners because they fear rejection and lack of emotional support (Des Jarlais, Chamberland, Yancovitz, Weinberg, & Friedman, 1984). Hispanic men, compared to Hispanic women, have more frequently reported that they would abandon their partners if the partners became infected with the AIDS virus (Marin & Marin, 1987).

The possibility of expanded HIV infection through heterosexual intercourse is made more salient by the fact that some cultural groups, such as Hispanics, engage in sexual intercourse outside of marriage as a demonstration of virility, behavior that often involves prostitutes (Carrier, 1985). Recent reports (CDC, 1987) have indicated that a higher proportion of minority prostitutes (15%) test positive for the HIV antibody than do White prostitutes (7%). Furthermore, studies are inconsistent on the actual rate of condom use among prostitutes, with some reporting high (78%) use (CDC, 1987) and some reporting minimal use (Rosenberg & Weiner, 1988; Shedlin, in press).

Prevention and educational programs should provide information to male IV drug users and their partners about the risks of HIV infection directly associated with unsafe sexual practices or IV drug use and indirectly associated with consumption of disinhibiting drugs such as alcohol, cocaine, and marijuana. Contraception information would be an essential component of this prevention approach, and considerable social support must be offered to minority men and women to help them develop the social skills to reduce their risks of HIV infection. Several circumstances increase the difficulty minority men and women have in complying with this risk reduction strategy, including women's emotional or economic dependence upon their male partners, the threat of physical coercion from partners, and the physical and psychological discomfort attributed to condoms.

However, the cultural value of the family may be extremely useful for influencing acceptance of condom use (G. Marin & Triandis, 1985). The possible negative impact on the family, especially on children, may increase the motivation of minority couples to use condoms or to abstain from intercourse if either partner is HIV positive. Similarly, machismo among Hispanics may also be useful in influencing risk reduction behavior among men (B. Marin et al., 1987) because this cultural value emphasizes the man's role in assuming responsibility for and protection of the family. Hispanic male IV drug users may be more likely to comply with condom use if AIDS prevention educators and researchers consider this cultural value. Machismo may have negative effects if it encourages high-risk sexual activity with extramarital partners or evokes hostile behavior when female partners decline sexual intercourse.

Conclusion

The preceding discussion indicated the high incidence of AIDS among Black and Hispanic men and the issues involved in developing culturally appropriate prevention strategies to reduce further transmission of HIV. Although various problems were discussed in developing successful programs (e.g., lack of information, difficulties in approaching target groups), the necessary components of these programs were suggested from research in other areas of behavior change. First, and most important, information must be provided in a culturally appropriate manner, and channels of dissemination must be used that will reach the target groups. This approach requires consideration of the appropriate vocabulary, language, and sophistication of the targeted ethnic minority group. Also, references should be made to the manner in which the problem is misperceived by the target group (e.g., "AIDS is a gay White male disease"). Furthermore, this approach should not rely on fear arousal tactics that would be either ineffective or counterproductive.

Second, the cultural values, norms, expectations, and attitudes of the target group need to be integrated into the messages and into the format of interventions. The implication of this suggestion is that minority prevention programs cannot include literal translations from English-language programs that have been successful with White gay men or White IV drug users but instead should be initially developed for the minority target group for which they are being provided. Consequently, these programs will reflect the values of the ethnic group and the preferred social scripts of that particular culture.

Finally, additional research is needed to adequately address the issues involved in developing culturally sensitive prevention programs. Unfortunately, both because of limited funding and the relative unavailability of minority researchers, there is a lack of data on Blacks and Hispanics useful in developing AIDS prevention strategies in minority communities. One important response to these limitations should be to increase government funding of minority prevention research. Increased training for minority researchers and culturally sensitive nonmi-

nority researchers will also help increase AIDS prevention research among non-White populations.

The high incidence of AIDS among minority men, especially Blacks and Hispanics, raises the possibility that the epidemic may have catastrophic consequences on these minority populations. If these possible consequences are to be avoided, prevention efforts must be increased dramatically and expeditiously. Until these prevention campaigns are available and unless they are successful, those consequences may be unavoidable.

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AFRICAN AMERICAN CULTURAL PATTERNS

Asa Hilliard* has described African American cultural patterns and behaviors as follows:

1. Afro-American people tend to respond to things in terms of the whole picture instead of its parts. The Euro-American tends to believe that anything can be divided and subdivided into pieces and that these pieces add up to a whole. Therefore, art is sometimes taught by numbers, as are dancing and music. That is why some people never learn to dance. They are too busy counting and analyzing.
2. Afro-American people tend to prefer inferential reasoning to deductive or inductive reasoning.
3. Afro-American people tend to approximate space, numbers, and time rather than stick to accuracy.
4. Afro-American people tend to prefer to focus on people and their activities rather than on things. This tendency is shown by the fact that so many Black students choose careers in the helping professions, such as teaching, psychology, social work and so forth, even though a scarcity of jobs exist in those areas and the curriculum is not particularly easy.
5. Afro-American people have a keen sense of justice and are quick to analyze and perceive injustice.
6. Afro-American people tend to lean toward altruism, a concern for one's fellow man.

7. Afro-American people tend to prefer novelty, freedom, and personal distinctiveness. This is shown in the development of improvisations in music and styles of clothing.
8. Afro-American people in general tend not to be "word" dependent. They tend to be very proficient in nonverbal communications.

*Hilliard, Asa., Alternatives to IQ testing: An approach to the identification of gifted minority children. Final report to the California State Department of Education, 1976, pp. 38 - 39

STYLES OF LEARNING

According to Asa Hilliard* Black Children learn best from a relational, interactive cognitive style while Euro-American children tend to learn best from a rational, analytical cognitive style.

Some of the examples of both styles are --

Rational

Think of how it is suppose to be.
(May also be described as analytical)

Precision
Memory for specific facts
Controlled
Deductive
Things focused
Rules
Standardization
Conformity
Rigid order
Differences equal deficits
Preconceive
Direct
Meanings are universal
Mechanical
Cognitive
Hierarchical
Isolation
Duty
Sign oriented

Relational

Think of how you can make it be.
(May also be described as interactive)

Approximate
Memory for essence
Expressive
Inductive
People focused
Freedom
Variation
Creativity
Flexibility
Sameness equals oppression
Improvise
Indirect
Meanings are contextual
Humanistic
Affective
Democratic
Integration
Loyalty
Meaning oriented

Hilliard, ASA, Alternatives to IQ testing: An approach to the identification of gifted minority children. Final report to the California State Department of Education, 1976.

AIDS/THE INSIDE STORY*By Randy Shilts***Black Response Lags Behind Epidemic**

Washington

When local leaders of Black and White Men Together, a group of black gay men, recently approached black ministers about backing a demonstration to raise awareness about AIDS in the black community, they were aghast at the response.

"Some of them said, 'We can't support sodomy — we can't support the march,'" said Douglas Conrad, a demonstration organizer. "As far as some of them are concerned, this is a gay problem."

The attitude reflects a reality that has emerged as one of the thorniest, albeit least discussed, problems within the AIDS epidemic today. Most black political leaders have yet to take AIDS seriously as a major threat to African Americans.

There are startling statistics concerning the dimensions of the AIDS threat for black Americans. Although blacks comprise about 11 percent of all Americans, for example, they make up 26 percent of the nation's 88,096 AIDS cases.

Moreover, the proportion of blacks among all cases of acquired immune deficiency syndrome has been creeping steadily upward. In 1984, 24 percent of reported AIDS cases were among blacks; last year, blacks represented 28.3 percent of new AIDS cases. In the inner cities of the Northeast, blacks have long represented the majority of AIDS sufferers.

All the official prognosticators say that the situation can only deteriorate as poor intravenous drug users, their sexual partners and their infants come to make up a larger share of the nation's AIDS cases.

In impoverished, heavily black neighborhoods like the Bronx, surveys have found that at least 1 in 20 young women are infected with the human immunodeficiency virus. This is an infection rate on par with the horrific levels of AIDS seen in Africa.

These statistics translate into a grim outlook: Without any doubt, AIDS will be one of the two or three preeminent issues facing the black community in the 1990s.

Few black politicians have demonstrated much leadership — or even much interest — in the issue. This has long frustrated AIDS researchers and public health officials, although they have been reluctant to discuss the question publicly for fear of being branded as racist.

But Conrad and other AIDS organizers are getting ready to demand that the silence be broken. When some of the nation's most powerful black leaders gather in Oakland for the National Black Mayors' Conference this weekend, they are slated to be greeted by uninvited guests — demonstrators protesting the lack of involvement

in AIDS issues by black leaders.

The main reason for the lack of visible black leadership, just about everybody agrees, is the antipathy many black leaders feel for anything related to homosexuality.

"They've been reluctant to take up the issue of AIDS, primarily because of its affiliation with the gay community," says Conrad, an organizer of this week's Oakland demonstration. "The reluctance is slowly being broken because the impact of AIDS on the minority community is so huge that it can no longer be denied."

The issue of homophobia has not been resolved.

Although politically liberal, many black leaders tend to be Protestant ministers and are very conservative on social issues. There has been little eagerness to join the battle against the AIDS epidemic.

For example, Chicago has a black mayor and more black political power than just about any big city in the United States. But the city government has done one of the worst jobs in dealing with the AIDS crisis, largely ignoring the disease even as it claims more and more black lives.

In Washington, the black congressional caucus has been virtually invisible on AIDS-related issues, leaving the lobbying and legislative finagling to be performed by

the handful of congressional representatives from heavily gay enclaves in San Francisco, New York and Los Angeles.

Closer to home, county officials in Alameda County, where nearly half of AIDS cases are among nonwhites, have come under intense criticism for giving short shrift to the fight on AIDS.

"Supposedly, this is a bastion of black leadership," complains Larry Saxxon, executive director of the AIDS Project of the East Bay.

Some black leaders, such as Jesse Jackson, have countered that the lack of focus on AIDS is understandable for a black leadership that is already struggling with urban crime, rampant poverty and the dismal lack of educational and employment opportunities for black youth.

But the wholesale fatalities that lie ahead if AIDS is not urgently confronted among minorities threaten to dwarf even these problems, and the situation will not improve if this is ignored. The battle against AIDS is a race against time. The longer it takes a community to organize its response to the epidemic, the longer the disease can move unchecked. The lack of leadership among black politicians today is allowing AIDS to win this deadly race. That means that African Americans will die.



Western Region AIDS Education Project
Comprehensive Health Center

State's blacks hardest hit by AIDS

The Associated Press

SACRAMENTO — Twelve times as many black women giving birth as white women were infected with the AIDS virus in a study released Thursday by state health officials.

"These results underscore the seriousness of the AIDS epidemic in the black community in California," said state Health Services Director Kenneth Kizer.

The department anonymously tested blood specimens from 135,762 births by California women during July, August and September 1988.

The rate of human immunodeficiency virus infection statewide was 7.4 per 10,000 women giving birth, or one in every 1,351 new mothers.

Among the 9,364 black women whose babies were tested, the rate

of HIV infection was one in every 275. The rate for the 53,306 white women was one in 3,332. Of the 44,063 Hispanic women tested, the rate was one in 1,377.

Women giving birth in the six counties in the San Francisco area and in Los Angeles County had higher HIV infection rates. The rate was one in 777 in the Bay area and one in 1,043 in Los Angeles County.

Orange County Register, Evening Edition (News Section)
September 8, 1989, p.A-6

State Blacks Hard Hit by AIDS

By David Perlman
Chronicle Science Editor

The AIDS epidemic is spreading more swiftly among California's black population than any other ethnic group in the state, and prospects are even grimmer for the future, state health department analysts reported yesterday.

In a detailed statistical report, Dr. Kenneth Kizer, California's health director, warned that the incidence of the disease among blacks will nearly triple over the next three years.

It is already rising three times faster among blacks than among whites and all other ethnic groups, he said.

Minorities Hard Hit

The report is one of a series being prepared by state and local AIDS workers who are growing increasingly concerned that the epidemic is hitting minority groups heavily and that the need for specialized AIDS educational material focusing on those groups is barely being met.

One indication of concern among minority communities is a demonstration planned for 1:30 p.m. Saturday at Oakland City Hall, where the National Conference of Black Mayors will be meeting on April 4. Leaders of ethnic organizations throughout the Bay Area will call for stronger efforts at AIDS education, prevention and treatment during the demonstration.

The analysis of acquired immune deficiency syndrome among California blacks was prepared by the research and statistics section of the state's AIDS office. It showed that the disease has already strick-

AIDS is striking San Francisco blacks four times more heavily

en 2,073 black men and women in California, and it estimated that the number will increase to 6,576 by the end of 1991. About 2 million of California's 28 million residents are black.

Near the end of the first decade since the AIDS epidemic began, the disease will have afflicted a total of 1,140 blacks in San Francisco by 1991, the report estimated, plus an additional 1,276 in the rest of the Bay Area and 2,790 in Los Angeles.

More Cases in S.F.

The report noted that AIDS is striking San Francisco blacks four times more heavily than it is the rest of the state's black population. The epidemic has hit 410 San Francisco blacks since 1981, which indicates a case rate of 403 per 100,000, and the statewide incidence of AIDS among blacks is 93 per 100,000.

The incidence of AIDS throughout the state's black population could increase to 300 per 100,000 by the end of 1991, the report said — but in San Francisco that case rate could reach 1,136 per 100,000.

Gay men and bisexual men account for the largest number of AIDS cases among blacks by far — just as they do among the rest of the population — but intravenous drug use has now become the most rapidly rising cause of AIDS among both black men and women. The increase among drug users is dangerous because so many addicts share their contaminated needles and syringes.

Intravenous drug use caused 8 percent of the AIDS cases in blacks by 1986, and the proportion soared to 18.5 percent last year.

Black Women

Among black women, the problem of drugs and needles is becoming even worse: Nearly half of them who have contracted AIDS used contaminated needles to inject drugs, and a third of the black women with AIDS contracted the disease through heterosexual contact with male intravenous drug users.

Referring to the spread of the human immunodeficiency virus, known as HIV, which causes AIDS, the report concluded:

"The grimness of this picture underscores the need for further intensification of efforts to prevent the spread of HIV among blacks in California."

PERSPECTIVES OF AFRICAN AMERICAN SEXUAL MINORITIES

PREPARED FOR TRESP ASSOCIATES, INC.

BY

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PERSPECTIVES OF AFRICAN AMERICAN SEXUAL MINORITIES

The term "sexual minority" is used as an inclusive and embracing term for homosexual or gay men and women, lesbians, bisexuals, and transpersons (transvestite, transsexual, transgender, female/male impersonators, and androgynous). Terms that some people use to refer to sexual minorities (such as sissy, homo, fairy, drag queen or queen, dyke) have negative connotations. However, some sexual minorities may use these terms among themselves and with very close friends -- just as some African Americans may refer to themselves with colloquialisms that are offensive when used by non-African Americans.

1. THE LEXICON OF SEXUAL MINORITIES

The term "homosexual" refers to men and/or women who are sexually attracted to and intimate with persons of the same gender and is usually used in clinical, research, or a professional manner that speaks of individuals only in terms of their sexual orientation and behavior.

Lesbian refers to women whose sexual orientation and preference is for other women. Because it gives them a specific identity, and avoids confusing their issues with those of gay men, some women prefer the term "lesbian" to "homosexual" or "gay."

Gay refers to both men and women and came into use during the 1960s to connote both a sexual orientation for the same gender, and an accepted lifestyle, a political-social consciousness, and a non-illness/clinical image. Many women prefer the term "gay" to "lesbian" or "homosexual."

Bisexual refers to men and women whose sexual orientation is for both men and women. Some experts argue that all persons are bisexuals, while others argue that bisexuality does not exist. Most bisexuals are "serial bisexuals"--meaning that they are not relating to a man and woman at the same time, but for a number of months or years may be sexually intimate with a woman and at another period be sexually intimate with a man. Persons in institutional settings may be labeled "situational bisexuals" -- meaning that they become sexually intimate with a person of the same gender because they do not have access to the opposite gender. When given a choice, these persons usually discontinue their same-gender relationships and become involved in a heterosexual relationship.

Transperson refers to men or women who cross-dress or other-wise cross the cultural boundaries of gender clarity via make-up, hair,

and demeanor. While there may be some confusion about the gender of these persons, cross-dressing is not in and of itself an indication of the person's sexual orientation.

Transvestites (TVs) are men and women who cross dress for sexual pleasure, but do not desire to change their gender. Most TVs are heterosexual men, however, most visible TVs are gay men.

Transsexuals are men and women who emotionally feel that they are trapped in the body of the wrong gender and desire to physically change their gender via hormones and surgery. Most transsexuals are men who may or may not be gay.

Transgenders are men and women who emotionally feel that they are trapped in the body of the wrong gender but do not desire to have surgery for sexual reassignment; however, they do opt for hormone treatments.

Androgynous Persons are men or women whose behavior and appearance does not convey whether they are male or female.

Gender Mess Ups are men and women who may wear some clothing of another gender, but make no effort to hide their true gender. Usually such cross dressing is done to raise social consciousness about the culture restrictions of gender roles.

2. COMMONLY HELD BELIEFS AND QUESTIONS BY AFRICAN AMERICANS ABOUT HOMOSEXUALITY

(1) How Prevalent Is Homosexuality In The African American Community?

To the same extent that homosexuality exists in other racial/ethnic communities, so homosexuality exists in the African American community. The most widely quoted Kinsey studies (1947, 1953) found that 13 percent of men and 7 percent of women were exclusively gay or lesbian throughout their lives and that 37 percent of the men surveyed had one or more homosexual experience. There have been no significant studies of homosexuality in African American communities for experts to discern whether the prevalence of homosexuality is higher or lower among African Americans. What we do know is that sexual minorities are immeshed in every social, economic, religious, educational, and professional sub-culture within the African American community.

(2) Do We Know What "Causes" Homosexuality?

Experts do not know why some persons are heterosexual while others are homosexual or bisexual. It is believed that a person's sexual orientation is determined by age two, although the individual may not acknowledge or act on his/her feelings until he/she is a teenager or a mature adult. The Freudian notions of family structure -- dominant mother, passive father or vice versa cause of homosexuality have been disproved (although many prominent

African American professionals still cling to these outdated theories). Sexual minorities have been raised in various family structures and environments which do not seem to be a determinant factor of homosexuality. It is not uncommon that the sexual orientation of twins may differ, or that in a household of several children raised under the same conditions and the same parents, a few may be gay or bisexual while the others may be heterosexual. Thus, we cannot say that the "cause" of homosexuality is hereditary, genetic, environmental, or parental up-bringing. Perhaps when we learn the "cause" of heterosexuality we will also learn the "cause" of homosexuality.

(3) Is Homosexuality A Choice Or Lifestyle?

Homosexuality is a sexual orientation, not a sexual preference. One's choice of a partner or sexual behavior is a preference or choice. Many experts believe that sexual orientation is determined by the time a child is two years old. The choices or preferences that a sexual minority makes are whether to act on one's orientation, whether to be open and revealing about one's orientation, and whether to adopt a lifestyle that embraces a gay social, political and support network. No therapeutic, religious, or punitive efforts have successfully changed a person's sexual orientation although one's sexual preference (in terms of behavior, choice of partner, and lifestyle) may change.

(4) Isn't Homosexuality Unnatural & Immoral?

For the more than 22 million Americans who identify themselves as sexual minorities, their acts of intimacy (hugging, kissing, masturbation, oral sex, and anal sex) are consenting, pleasurable, natural, safe, without guilt, and felt to be within their moral standards. It is the taboos imposed by our society or culture that lead us to believe that pleasurable acts of intimacy are unnatural or immoral. That which is taboo or immoral in one culture (like men kissing or hugging) may be the norm in another.

Taken literally and often out of context, the Bible and other religious teachings have been used to encourage slavery, reinforce the inferiority of women, prohibit eating shrimp and shellfish, prohibit using makeup and the wearing of red dresses, and the like. Thus, we are encouraged to question the logic of moral teachings which tend to oppress and persecute groups of people. The oppression of sexual minorities is often compared to that of Jews, African Americans, and other racial/ethnic minorities.

(5) Is Homosexuality A Mental Illness And Are Homosexuals Sick?

Being a sexual minority does not in and of itself mean that one is mentally ill, has a psychological disorder, or is emotionally unhappy or maladaptive. In the 1970s the American Psychological Association and the American Psychiatric Association removed homosexuality from the list of mental disorders. In fact, several studies have found no difference between heterosexuals and homosexuals with respect to self esteem, alcohol and drug use, suicide rates, family relations, and general satisfaction with life.

(6) Are Gay Men And Women Promiscuous?

A small number of gays do have many sexual partners; however, the majority of gays do not. One is more likely to hear or read about those sexual minorities who have many and multiple sexual partners than about the large number of sexual minorities who have been in stable, monogamous relationships for many years. Studies conducted prior the AIDS crisis reveal that about 60 percent of lesbians and 40 percent of gay men are in committed long-term relationships. Since the AIDS crisis, a larger percentage of gay men are settling down in stable relationships. Maintaining relationships is more difficult for sexual minority couples because society and racial/ethnic sub-cultures do not provide many of the supports for those relationships that are provided to heterosexual couples. Minimal social, legal, religious, or family support exists for sexual minority couples. Many of the myths and mystics that exist about African American sexuality (i.e. the "hot Black mamma" and the "Black stud") and fears about interracial marriages and sexuality (i.e. unnatural and against God's will) also exist about gays and lesbians.

(7) Do Lesbians Really Want To Be Men and Gay Men Really Want To Be Women?

Most lesbians and gays do not confuse their gender status with their sexual orientation and do not wish to change their sexual orientation. The very nature of gay relationships provides an impetus away from rigid sex-role stereotypes. Research indicates that there is no differences between homosexuals and heterosexuals in their gender identity; but, for survival, traditional roles are often abandoned. While some lesbian and gay couples do fall into roles and affectionately refer to each other as "wife" or "husband" or some gender label (i.e., girlfriend, boyfriend, Mary, "Miss Thing,"), most tend to break down sex roles rather than reinforce them. The exception may be transpersons of which only transsexuals want a gender reassignment.

(8) Do All Gay Men Like To Dress Like Women And Lesbians Like To Dress Like Men?

No, in fact, a very small percentage of gay men and lesbians like to cross dress. Cross dressing is a gender phenomena and is not in and of itself an indication of what the individual's sexual orientation may be. In fact, most male and female cross dressers are heterosexuals; most gay men are not effeminate; and most lesbians are not masculine. Some researchers believe that cross dressing and rigid sex roles are more prevalent in African American and Latino communities and in small/rural town areas than in society as a whole because of the lack of positive role models and the incorrect belief that to be a gay man means being a woman and that to be a lesbian means being a man. Gender identity is often confused with sexual orientation.

(9) Do Gay Men And Lesbians Molest Children?

Ninety seven percent of child molesting is perpetrated by heterosexual adult males and mostly on minor females. The "average" offender is a white heterosexual male in an adult relationship and is a man that the child knows. The adult male who molests boys is often a pedophile -- a man who is sexually attracted to children regardless of their gender. The media often sensationalizes child molestation cases involving gays and lesbians while many of the heterosexual molestation cases involving are not publicly disclosed. Most gay men and lesbians are sexually attracted to other lesbians and gays who are close to their own age.

(10) Do Gays Make Good Parents And Will Their Children Grow Up To Be Gay?

There is no evidence that children of gay men or lesbians are more likely to grow up be gay adults. In fact, many gay and lesbian parents take steps to conceal their lesbian/gay sexual orientation from their children. Gays and lesbians are often custodial parents through a prior or current heterosexual or bisexual marriage, through foster parenting or adoption (in which their sexual orientation often is not disclosed), through an extended family situation in which a parental role was assumed by default, or through an alternative fertilization/artificial insemination arrangement with a trusted friend.

11. Does Homosexuality Exist In Africa And Other African American Nations?

Yes, homosexuality does exist in African nations, the Caribbean, and in all countries among all peoples. However, that which we call a "gay" or "lesbian" lifestyle may be very different because

of culture differences. However, there are "gay" political and social groups in African nations. We also know that homosexuality has always been a part of all cultures, seemingly since the beginning of time.

(12) Is Bisexuality More Prevalent In The African American Community Than The White Community?

While there are some studies which support this belief, we do not know if the prevalence of bisexuality, homosexuality, or lesbianism is greater or less than the prevalence in the Caucasian or other racial/ethnic communities. We do know that many African American men and women reject the labels used to describe sexual minorities but continue to be sexually active with persons of the same gender.

(13) What Is The Prevalence Of IV Drug Use Among African American Gays?

A significant number of African American gays are injecting drugs. Nationally, 26 percent of the fully diagnosed AIDS cases are intravenous drug abusers (IVDAs) [19 percent are heterosexual and 7 percent are gay or bisexual men]. Examining this breakdown by race, we discover that among whites, 14 percent of the fully diagnosed AIDS cases are IVDAs (6 percent heterosexual and 8 percent gay or bisexual men) compared to 45 percent among African Americans (38 percent heterosexual and 7 percent gay or bisexual men). As of August 15, 1988 almost 18,000 African American adults had been diagnosed as having AIDS -- of which more than 8,000 (45 percent) are IVDAs. African American gay and bisexual IV drug using men account for about 1,300 (7 percent) of the total AIDS cases in the African American community and 15 percent of the IVDU AIDS cases in the African American community. If we are to believe the statistical data, numerically there are more Caucasian IV drug using gay and bisexual men (3,100) diagnosed with AIDS than there are African American IV drug using gay and bisexual men (1,300). However, because of the stigma attached to homosexuality and AIDS in the African American community, there is reason to believe that many African American men deny their sexual relationships with other men and may lie about a past history of substance abuse rather than admit to their homosexuality. For many African Americans, the stigma of a family member who has a history of substance abuse is not nearly as great the stigma of explaining that a family member was diagnosed with AIDS as a result of his sexual conduct.

(14) Are African American Lesbians At Risk For AIDS And HIV Infection?

To the extent that African American lesbians have a history of IV drug use, of prostitution, of having been in a heterosexual marriage, or of bisexuality, they may be at risk for HIV infection and AIDS. AIDS outreach workers have found a significant number of African American women who identify themselves as lesbians or bisexuals engage in prostitution and injecting drugs. The majority

of women diagnosed as having AIDS are themselves IV drug users or their partners are IV drug users. Since vaginal secretions and blood are two of the major body fluids in which HIV is found in high concentrations, lesbian women should be given safer sex and risk-reduction messages regarding use of dental dams or Saran wrap, use of sex toys, proper condom use, lubricants, and spermicides (if they are involved in prostitution or bisexuality), and drug paraphernalia (if they are involved in drug needle use).

(15) What About Bisexuality And Married Gays? And Why Do African American Gays And Lesbians Get Married?

Bisexuality is a reality. Some men and women feel sexually and emotionally attracted to both genders. Some men and women are not aware of their sexual attraction to the same gender until they are in their twenties, thirties, forties, or later. By this time they may have gotten married and had several children. These are some of the reasons that there are married gay men and women. Some African American gay men and women marry with the belief that if they settle down in a heterosexual marriage and have children their sexual desire for a person of the same gender will dissipate. Gays may indeed be able to internalize their emotions and not act on their desires to be sexual with the same gender, but this does not change the fact that they are gay or bisexual. Such an action can be compared to some African Americans who are able to "pass" as a Caucasian; the fact remains that the individual is African American. Unfortunately, some professionals (ministers, psychologists) still urge sexual minorities to marry and have children as a way to "get over" their homosexual feelings. To the same extent that it is not appropriate to counsel African Americans to "pass" as a Caucasian or to not acknowledge their African American identity, we should never counsel sexual minorities to be straight -- not even African American youth who may not be clear about their sexuality.

Other African American gay men and women marry for convenience and may work out an open marriage relationship through gay married, gay parenting, or bisexual support groups. Some gay men and lesbian women marry each other and may have all the makings of a marriage except sex. Some inform their intended spouses before they marry, while others never tell their spouses but continue in a discreet same gender relationship. Thus, bisexuality and homosexuality within a marriage or heterosexual relationship is not uncommon. In the era of AIDS, more than ever, we encourage each other to be open and honest about our true emotional feelings. Unfortunately, this is not likely to happen until we can lessen the stigma attached to homosexuality and become non-moralistic and non-judgmental about homosexuality. Otherwise, many African Americans will continue to give the facade of heterosexuality in the closet of homosexuality or bisexuality.

(16) As A Straight Woman, What Are Some Signs I Can Look For To Know If A Man Is Straight Or Gay?

There is no "cookbook" or guidelines for how gay and bisexual men (or women) look, act, talk, or walk. We could perhaps make a long list of mannerisms to watch for or verbal expressions to listen to, but we would be generalizing and typecasting in much

the same manner that society does regarding African Americans, Jews, women, Asians. Most gays are invisible and blend within the subculture of their racial identity.

One should be cautious about the man who is overly hostile about and towards gays, who routinely brags about his sexual encounters and seems to be always "on the make," and who seems to go out of his way to announce that he is straight. In all likelihood this is a man who is not comfortable with his sexuality and may be fighting his emotional feelings about his own homosexuality.

It is important to remember that our culture plays a large part in what is acceptable for men and for women. However, these gender issues and roles should not be confused with sexual orientation. Thus, our perception of effeminacy and masculinity and confusion about sexual orientation being a reversal of gender roles, lead us to believe that we can look at a man or woman to determine if he or she is gay. We also mistakenly believe that a person's work occupation will be a clue. Individuals should not make assumptions, but rather follow their instincts and "gut" feelings. Talk about the reality of bisexuality, situational bisexuality, and sexual fantasies. If a person is too uptight to discuss the issue or becomes defensive or hostile, then perhaps that is a clue that some compatibility problems exist.

(17) So Sexually, Just What Do Gay Men Do? And Lesbian Women?
How Do You Know Who's Sexually Active/Passive Or The
Insertee/Insertee?

For the most part, counselors do not need to know the personal sexual activities of a gay or lesbian client. Counselors do not need to become that personal in conducting risk assessments or in encouraging sexual minorities to engage in safer sex techniques. In truth, gay and lesbian clients tend to be very imaginative, communicative, and expressive of their sexual fantasies and engage in the same sexual practices as do heterosexuals. There are sexual activities that are uniquely homosexual or uniquely heterosexual. Many sexual minorities do not limit themselves to being a "top" or "bottom" partner or perceive themselves to be in a "wife" or "husband" role. It is important that counselors receive training in human sexuality and become sensitized to be non-judgmental about sexual acts, lifestyles, and orientations which counter their personal values.

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TRAVEL FACT SHEET

Transportation paid for by the Government must be purchased in the manner prescribed by 41 CFR 101-41.203. Your round trip tickets will be purchased by the National Commission on AIDS and mailed to you prior to the date of travel, or, in the case of an emergency, prepaid tickets will be sent to an airline ticket counter near your location. The Commission will provide hotel accommodations for you at the Governments expense. Other expenses which are reimbursable include \$34 per day for meals and incidental expenses and local transportation.

Mr. Frank Arcari, 202-254-5125, will handle your airline ticket and hotel arrangements. Please provide him with the following information: Dates of travel, city and state you are traveling from, your social security number, and home address.

If you will provide us with a list of your itemized expenses (Enclosure 1) at the conclusion of your trip together with the signed travel voucher form (enclosure 2), we will be glad to complete it for you so that you may be reimbursed.

**NATIONAL COMMISSION ON AIDS
TRAVELER VOUCHER ITINERARY
HEARINGS AND SITE VISITS**

Traveler _____

Date travel began: _____

Time you left your: _____

Residence _____ **Office** _____

Mode of Travel:

Privately owned vehicle - Round trip mileage to airport _____

Parking fee at Airport \$ _____

Taxi fare \$ _____

Departure time from Airport or Train station: _____

Arrival time at destination: _____

Taxi fare to Hotel	\$ _____	Date _____
Taxi fare to Hearing	\$ _____	Date _____
Taxi fare to Hotel	\$ _____	Date _____
Taxi fare to Hearing	\$ _____	Date _____
Taxi fare to Hotel	\$ _____	Date _____
Taxi fare to Airport	\$ _____	Date _____

Departure time from Airport: _____ **Date** _____

Taxi fare to Residence \$ _____
Office \$ _____

Arrival time at Residence: _____ **Office** _____

Miscellaneous:

Commission Business Telephone calls - Local calls (sum) \$ _____

Long distance calls must be itemized, please submit a copy of these expenses.

Conference registration fee: \$ _____

**NOTE: A receipt is only required for an expense over \$24.99
excluding meals.**

SCHEDULE OF EXPENSES AND AMOUNTS CLAIMED	INSTRUCTIONS TO TRAVELER <i>(Unlisted items are self-explanatory)</i>		Complete this information if this is a continuation sheet.	PAGE _____ OF _____ PAGES	
	Col. (c) If the voucher includes per diem allowances for members of employee's immediate family, show members' names, ages, and relationship to employee and marital status of children (unless information is shown on the travel authorization.)	Complete only for actual expense travel	Col. (d) thru (g)	TRAVEL AUTHORIZATION NO.	
			Show amount incurred for each meal, including tax and tips, and daily total meal cost. (h) Show expenses, such as: laundry, cleaning and pressing of clothes, tips to bellboys, porters, etc. (other than for meals). (i) Complete for per diem and actual expense travel. (j) Show total subsistence expense incurred for actual expense travel. (m) Show per diem amount, limited to maximum rate, or if travel on actual expense, show the lesser of the amount from col. (j) or maximum rate. (n) Show expenses, such as: taxi/limousine fares, air fare (if purchased with cash), local or long distance telephone calls for Government business, car rental, relocation other than subsistence, etc.	TRAVELER'S LAST NAME	

TRAVEL AUTHORIZATION NO.

TRAVELER'S LAST NAME

In compliance with the Privacy Act of 1974, the following information is provided: Solicitation of the information on this form is authorized by 5 U.S.C. Chap. 57 as implemented by the Federal Travel Regulations (FPMR 101.7), E.O. 11609 of July 22, 1971, E.O. 11012 of March 27, 1962, E.O. 9397 of November 22, 1943, and 26 U.S.C. 6011(b) and 6109. The primary purpose of the requested information is to determine payment or reimbursement to eligible individuals for allowable travel and/or relocation expenses incurred under appropriate administrative authorization and to record and maintain costs of such reimbursements to the Government. The information will be used by officers and employees who have a need for the information in the performance of their official duties. The information may be disclosed to appropriate Federal, State, local, or foreign agencies, when relevant to civil, criminal, or regulatory investigations or prosecutions, or when pursuant to a requirement by this agency in connection with the hiring or firing of an employee, the issuance of a security clearance, or investigations of the performance of official duty while in Government service. Your Social Security Account Number (SSN) is solicited under the authority of the Internal Revenue Code (26 U.S.C. 6011(b) and 6109) and E.O. 9397, November 22, 1943, for use as a tax payer and/or employee identification number; disclosure is MANDATORY on vouchers claiming travel and/or relocation allowance expense reimbursement which is, or may be, taxable income. Disclosure of your SSN and other requested information is voluntary in all other instances; however, failure to provide the information (other than SSN) required to support the claim may result in delay or loss of reimbursement.

**NATIONAL COMMISSION ON AIDS
TRAVELER VOUCHER ITINERARY
HEARINGS AND SITE VISITS**

Traveler _____

Date travel began: _____

Time you left your: _____

Residence _____ **Office** _____

Mode of Travel:

Privately owned vehicle - Round trip mileage to airport _____

Parking fee at Airport \$ _____

Taxi fare \$ _____

Departure time from Airport or Train station: _____

Arrival time at destination: _____

Taxi fare to Hotel	\$ _____	Date _____
Taxi fare to Hearing	\$ _____	Date _____
Taxi fare to Hotel	\$ _____	Date _____
Taxi fare to Hearing	\$ _____	Date _____
Taxi fare to Hotel	\$ _____	Date _____
Taxi fare to Airport	\$ _____	Date _____

Departure time from Airport: _____ **Date** _____

Taxi fare to Residence \$ _____
Office \$ _____

Arrival time at Residence: _____ **Office** _____

Miscellaneous:

Commission Business Telephone calls - Local calls (sum) \$ _____

Long distance calls must be itemized, please submit a copy of these expenses.

Conference registration fee: \$ _____

**NOTE: A receipt is only required for an expense over \$24.99
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	Col. (c) If the voucher includes per diem allowances for members of employee's immediate family, show members' names, ages, and relationship to employee and marital status of children (unless information is shown on the travel authorization).	Complete only for actual expense travel	Col. (d) thru (g) Show amount incurred for each meal, including tax and tips, and daily total meal cost. (h) Show expenses, such as: laundry, cleaning and pressing of clothes, tips to bellboys, porters, etc. (other than for meals). (i) Complete for per diem and actual expense travel. (j) Show total subsistence expense incurred for actual expense travel. (m) Show per diem amount, limited to maximum rate, or if travel on actual expense, show the lesser of the amount from col. (j) or maximum rate. (n) Show expenses, such as: taxi/limousine fares, air fare (if purchased with cash), local or long distance telephone calls for Government business, car rental, relocation other than subsistence, etc.	TRAVEL AUTHORIZATION NO. _____	
				TRAVELER'S LAST NAME _____	

In compliance with the Privacy Act of 1974, the following information is provided: Solicitation of the information on this form is authorized by 5 U.S.C. Chap. 57 as implemented by the Federal Travel Regulations (FPMR 101.7), E.O. 11609 of July 22, 1971, E.O. 11012 of March 27, 1962, E.O. 9397 of November 22, 1943, and 26 U.S.C. 6011(b) and 6109. The primary purpose of the requested information is to determine payment or reimbursement to eligible individuals for allowable travel and/or relocation expenses incurred under appropriate administrative authorization and to record and maintain costs of such reimbursements to the Government. The information will be used by officers and employees who have a need for the information in the performance of their official duties. The information may be disclosed to appropriate Federal, State, local, or foreign agencies, when relevant to civil, criminal, or regulatory investigations or prosecutions, or when pursuant to a requirement by this agency in connection with the hiring or firing of an employee, the issuance of a security clearance, or investigations of the performance of official duty while in Government service. Your Social Security Account Number (SSN) is solicited under the authority of the Internal Revenue Code (26 U.S.C. 6011(b) and 6109) and E.O. 9397, November 22, 1943, for use as a tax payer and/or employee identification number; disclosure is MANDATORY on vouchers claiming travel and/or relocation allowance expense reimbursement which is, or may be, taxable income. Disclosure of your SSN and other requested information is voluntary in all other instances; however, failure to provide the information (other than SSN) required to support the claim may result in delay or loss of reimbursement.

Enter grand total of columns (l), (m) and (n), below and in item 13 on the front of this form.

TOTAL AMOUNT CLAIMED ▶



NATIONAL COMMISSION ON ACQUIRED IMMUNE DEFICIENCY SYNDROME

1730 K Street, N.W., Suite 815
Washington, D.C. 20006
(202) 254-5125 [FAX] 254-3060

Chairman June E. Osborn, M.D. is the Dean of the School of Public Health at the University of Michigan and Professor of Pediatrics and Communicable Diseases at the University of Michigan Medical School. She also serves on numerous federal and non-federal committees, including the AIDS Research Advisory Committee of the National Institute of Mental Health; the Ad Hoc Working Group on AIDS and the Nation's Blood Supply (Chair) for the National Heart, Lung and Blood Institute; the WHO Global Commission on AIDS; and the Robert Wood Johnson Foundation National Advisory Committee for AIDS Health Services Program (Chair). Dr. Osborn has researched and published extensively in the field of virology. She earned her M.D. at Case Western Reserve University School of Medicine.

Vice Chairman David E. Rogers, M.D. has had an interesting and varied career since he completed his M.D. in 1948 at Cornell University and served an internship and residency at Johns Hopkins. Among his important appointments are those of Dean of Medicine and Vice President for Medical Affairs at Johns Hopkins University, and Medical Director of the Johns Hopkins Hospital. Dr. Rogers was appointed as the first Walsh McDermott University Professor of Medicine at the NYH-CUMC in November 1986. For the 15 years preceding this appointment, Dr. Rogers was the President of the Robert Wood Johnson Foundation in Princeton, N.J., the largest philanthropy devoting its resources to alleviating problems in the health care of Americans. Dr. Rogers has been very involved in the problems of AIDS, holding appointments as Chairman of the Advisory Council of the AIDS Institute of New York State, as a member of the Citizens Commission on AIDS of New York and New Jersey, Chair of the Scientific Advisory Committee, NYH Partnership Advisory Committee, and Chair of the New York City Mayoral Task Force on AIDS.

As Consultant to the Christian Life Commission of the Baptist General Convention of Texas, Scott Allen has done extensive research on the spiritual, ethical, and psychological dimensions of AIDS. He also provides direct pastoral care for people with AIDS, and is often called upon to act as a liaison between PWA's and their religious community and/or family. In addition, Reverend Allen is the founder and Co-Coordinator of the AIDS Interfaith Network of Dallas, Chairperson of the Subcommittee on State Responsibility of the Special Texas Legislative Task Force on AIDS, and Board Member of AIDS ARMS, a program to meet the special human

needs of PWA's. Reverend Allen earned his Masters in Divinity from the Golden Gate Theological Seminary, and served as pastor of the Pacific Baptist Church in California and a Minister of Education and Youth for the First Christian Church in Colorado Springs before joining the Christian Life Commission in 1985.

Diane Ahrens is presently serving her fourth term as Commissioner of Ramsey County Minnesota. In 1987, she convened the Tri-County Task Force on AIDS to develop an AIDS Implementation Plan, which was passed unanimously by the Ramsey County Board in the Fall of 1988. In addition, as Chair of the National Association of Counties' Task Force on HIV and AIDS, Commissioner Ahrens has overseen the formulation of recommendations regarding the appropriate responsibilities of the county, state, and the federal governments in our nation's response to the AIDS epidemic. She earned her Masters Degree in Theology and Religious Education at Yale University.

Harlon Dalton is a Professor at Yale Law School and a leading authority on legal issues generated by the AIDS epidemic. His publications include, AIDS and the Law: A Guide for the Public, "AIDS: A Drama in Blackface" in Daedalus and "Thinking AIDS, Rethinking Law: An Ongoing Lesson in the Regulation of Human Behavior". Mr. Dalton serves on the Board of Directors of AIDS Project New Haven, the Advisory Board of the Connecticut Consortium of AIDS, and the Editorial Board of the AIDS Alert. He earned his J.D. from Yale Law School, and is a member of the Bar of New York, Connecticut, the Supreme Court of the United States, the United States District Court, and the United States Court of Appeals, Second Circuit.

Don C. Des Jarlais is currently the Director of Research for the Chemical Dependency Institute of Beth Israel Medical Center and Deputy Director for AIDS Research with Narcotic and Drug Research, Inc. He is an international leader in the fields of AIDS and intravenous drug use and during the last six years, Dr. Des Jarlais has published over 50 articles on the topics. He was the plenary speaker on intravenous drug use and AIDS at the 3rd and 4th International Conferences on AIDS and serves as consultant to various institutions, including the Centers for Disease Control, the National Institute on Drug Abuse, the National Academy of Sciences and the World Health Organization. He is a Guest Investigator at Rockefeller University and a Visiting Professor of Psychology with Columbia University. Dr. Des Jarlais earned his Doctorate of Philosophy in Social Psychology from the University of Michigan.

Eunice Diaz, M.S., M.P.H. is currently an Assistant Clinical Professor of Family Medicine at the University of Southern California School of Medicine. She is a nationally acclaimed authority and speaker on the subject of AIDS in the Hispanic community, and a former board member of AIDS Project Los Angeles. In addition, Ms. Diaz has served on numerous AIDS-related committees and panels, including the Los Angeles County Commission on AIDS, the Planning Committee for the Surgeon General's Conference on Pediatric AIDS, and most recently, the Task Force on AIDS of the Society for Hospital Marketing and Public Relations, American Hospital Association. Ms. Diaz earned a Master of Science in Public Health and a Master of Public Health at the Loma Linda University.

Donald S. Goldman is an attorney in private practice as a partner in the West Orange, New Jersey law firm of Harkavy, Goldman, Goldman & Caprio. Active in The National Hemophilia Foundation and its chapters for over 25 years, he served as its Chairman from 1983 to 1984 and its President from 1984 to 1986. Mr. Goldman coordinated the National Hemophilia Foundation's efforts to improve the safety of our nation's blood supply, started many of its efforts in HIV risk reduction and introduced initiatives to improve hemophilia and HIV service delivery to minorities. Currently he is also Vice-President of the National Health Council, Inc. Mr. Goldman earned his J.D. from Rutgers University, and has published and lectured widely on legal aspects of hemophilia, HIV infection, and other medical and ethical issues. He is a member of the Bar of New Jersey, the United States Court of Appeals for the Third Circuit, and the United States Supreme Court.

Larry Kessler is the Co-Founder and Executive Director of AIDS Action Committee in Boston, a community-based service organization staffed by 75 full-time employees and over 1,500 volunteers. In addition, he serves on the Massachusetts Governor's Task Force on AIDS and the Boston Mayor's Task Force on AIDS, under appointments by Governor Dukakis and Mayor Flynn, respectively. Kessler is also a longtime Catholic activist and a member of the Board of Directors of both the National Catholic AIDS Ministry in New York and the AIDS Action Council in Washington, D.C.. In 1987, Simmons College in Boston awarded him an Honorary Degree of Doctor of Human Services.

Charles Konigsberg, M.D., M.P.H. has been Director of the Division of Health of the Kansas Department of Health and the Environment since October of 1988. Previously, he was the District Health Program Supervisor and Broward County Public Health Unit Director for the Department of Health and Rehabilitative Services in Fort Lauderdale. In Florida, Dr. Konigsberg represented the

county health official perspective on the Governor's AIDS Advisory Task Force. Dr. Konigsberg has also served as a consultant to the Centers for Disease Control and the U.S. Public Health Service in the development of HIV prevention and control strategies. He earned his M.D. from the University of Tennessee Center for the Health Sciences and his Master of Public Health in Community Health Administration from the University of North Carolina School of Public Health.

Belinda Mason is a 31 year old mother of two children, who acquired AIDS through a blood transfusion. She was diagnosed with AIDS in January, 1987 and lived with the disease in an isolated, rural area, with no contact with other people with AIDS. In August 1988, she founded the first organization in Kentucky and Indiana for people with HIV disease. She has traveled around the country speaking about the human side of the AIDS epidemic and providing education and perspective to groups of all sizes and interests from college students, to health care professionals and national policy makers. Mrs. Mason is now the president of the National Association of People with AIDS.

J. Roy Rowland, M.D. is now serving his fourth term in the United States House of Representatives (Democrat, Georgia's Eighth Congressional District). As the only physician in Congress from 1985 to 1988, Congressman Rowland has provided leadership and insight on a number of health issues, such as infant mortality, rural health, the veterans' health system, and AIDS. His efforts on behalf of the AIDS community include sponsoring the legislation which authorized creation of the National Commission on AIDS and introducing a bill mandating study of AIDS among college students -- an idea which was adopted administratively by the Centers for Disease Control. Congressman Rowland earned his M.D. from the Medical College of Georgia, and maintained a family practice in middle Georgia for three decades before pursuing a political career.

Cabinet Secretaries

Louis W. Sullivan, M.D. was sworn in as Secretary of Health and Human Services March 10, 1989. As head of the Department of Health and Human Services, Dr. Sullivan oversees the federal agency responsible for the major health, welfare, food and drug safety, medical research and income security programs serving the American people. Dr. Sullivan came to HHS from the Morehouse School of Medicine in Atlanta, Georgia. In July 1975, Dr. Sullivan had become founding dean and director of the medical education program at Morehouse College. Since July 1, 1981 when the School of

Medicine became independent from Morehouse College, he had served as its first dean and president. In April 1985, the Morehouse School of Medicine was fully accredited and on May 17, 1985, the school awarded the M.D. degree to its first 16 graduates.

Edward J. Derwinski, President Bush's choice to become the first Secretary of the newly created Cabinet-level Department of Veterans Affairs, was confirmed by the Senate on March 2, 1989 and sworn in on March 15, 1989. Secretary Derwinski directs the activities of the federal government's second largest department, responsible for a nationwide system of health-care services and benefits programs for America's 27.3 million veterans. A member of the U.S. House of Representatives from 1959 to 1983, representing Illinois' Fourth Congressional District, he was senior minority member of the House Foreign Affairs Committee and the House Post Office and Civil Service Committee. He played a major role in the passage of landmark Civil Service Reform, Postal Service Reorganization, and Foreign Service Reform legislation.

Richard B. Cheney was nominated by President Bush to be Secretary of Defense on March 10, 1989, was confirmed by the United States Senate on March 17, 1989, and took the oath of office on March 21, 1989. In August 1974, when Gerald R. Ford assumed the Presidency, Mr. Cheney served on the Ford transition team and, beginning in September 1974, as a Deputy Assistant to the President. In November 1975, he was named Assistant to the President and White House Chief of Staff, a position he held through the remainder of the Ford Administration, until January 1977. He returned to his home state of Wyoming in May 1977 to resume private life. Mr. Cheney was elected to Congress in November 1978. He was re-elected in 1980, 1982, 1984, 1986, and 1988.

#

January, 1990



NATIONAL COMMISSION ON ACQUIRED IMMUNE DEFICIENCY SYNDROME

1730 K Street, N.W., Suite 815
Washington, D.C. 20006
(202) 254-5125 [FAX] 254-3060

CHAIRMAN

June E. Osborn, M.D.

MEMBERS

Diane Ahrens

Scott Allen

Hon. Richard B. Cheney

Harlon L. Dalton, Esq.

Don C. Des Jarlais, Ph. D.

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Eunice Diaz, M.S., M.P.H.

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David E. Rogers, M.D.

Hon. J. Roy Rowland, M.D.

Hon. Louis W. Sullivan, M.D.

EXECUTIVE DIRECTOR

Maureen Byrnes, M.P.A.

December 7, 1990

Mr. Reggie Williams
Executive Director
Men of All Colors Together, Inc.
273 Church Street
San Francisco, CA 94114

Dear Mr. Williams:

On behalf of the National Commission on Acquired Immune Deficiency Syndrome, I would like to thank you for agreeing to participate in the Commission's hearing on Monday, December 17, 1990.

The hearing will focus on HIV disease in African American communities. We hope to create a discourse, looking at HIV disease in its larger social context and to explore opportunities for action. Through our discussions we also hope to create a greater understanding of HIV disease in African American communities and generate relevant policy recommendations.

The format will be four panels, each panel comprised of a presenter followed by commentary by several respondents. Following each presentation there will be time for questions. You are scheduled to participate on the panel "Determining What is Culturally Appropriate" which is tentatively scheduled for 3:15 p.m. A complete agenda will be sent to you early next week.

The hearing will be held in the Curran Conference Room which is located on the fourth floor of the City Hall, 100 North Holliday Street, Baltimore, Maryland. We have asked participants to try to meet informally Sunday evening at the Peabody Court Hotel.

All hearing participants are requested to send a biographical statement, one paragraph in length, to the Commission office by December 13th. This information may be transmitted by facsimile to (202) 254-3060.

Travel arrangements will be made through our office. A summary of federal travel regulations and necessary forms are enclosed. Please contact Frank Arcari in the Commission office at your earliest convenience for assistance.

We look forward to seeing you on the 17th.

Sincerely,

Maureen Byrnes
Maureen Byrnes
Executive Director

KURT L. SCHMOKE
MAYOR

AND

ELIAS DORSEY
ACTING COMMISSIONER OF HEALTH

CITY OF BALTIMORE

request your presence
at a
Reception

on Monday, the seventeenth of December
at six o'clock

City Hall Rotunda

DEC 12 '90 16:12 YALE LAW SCHOOL

P.1/2

**YALE LAW SCHOOL**401A YALE STATION
NEW HAVEN, CONNECTICUT 06520
U. S. A.

FAX #: 203 432-2592

FAX #: 203 432-7362

FAX #: 203 432-8260

FASCIMILE TRANSMISSIONDATE: 12/12/90TO: Reggie WilliamsFROM: Harlon C. DaltonNO. OF PAGES: 2
(including this page)If the transmission is incomplete or illegible, please call: 203-432-4956 (J.I.I)

TRANSMITTED FROM (203) 432-8260 (MURATA FAX F-30)

MESSAGE:



YALE LAW SCHOOL
401A YALE STATION
NEW HAVEN, CONNECTICUT 06520

HARLON L. DALTON

(203) 432-4933
December 12, 1990

Reggie Williams, Executive Director
Men of All Colors Together, Inc.
273 Church Street
San Francisco, CA 94114

Dear Reggie:

I just wanted to take a minute to say how personally pleased I am that you have agreed be a panelist at the National Commission on AIDS hearing this coming Monday. I have a really good feeling about this meeting and know in my gut that you and the others will do us all proud.

While I'm at it, let me say a word or two about the philosophy of this hearing (if that isn't too grand a term). I'm probably just repeating what you've been told by Karen Porter or Jane Silver, but it's better to err on the side of repetition. Our goal at this hearing is to take on some of the really tough issues posed by AIDS in African American communities and to explore them with greater candor and in greater depth than is usually the case. Therefore, rather than invite 30 or 40 people to come and speak for five minutes about their latest research, the organization with which they are involved, or their crying need for funding, we have asked roughly a dozen thoughtful people to engage in a discussion, in the Commission's presence, of shared concerns that cut across our organizational affiliations, pet projects, etc. We have asked the four presenters to meet informally with each of the respondents prior to Monday morning so that you will know in advance direction and tone the presentations will set and what you might offer that could broaden or deepen the conversation. You are not expected to produce, and certainly should not read from, a prepared text. The basic idea is for a session that is interactive. As always, we have built in at least half an hour per panel for dialogue with the members of the Commission.

I'm looking forward to seeing you Sunday night and working with you on Monday.

Best wishes,

Harlon L. Dalton

NATIONAL COMMISSION ON AIDS
HEARING
HIV DISEASE IN AFRICAN AMERICAN COMMUNITIES

Curran Conference Room
100 North Holliday Street
City Hall
Baltimore, Maryland

AGENDA

Monday, December 17, 1990

8:30 a.m. - 8:40 a.m.	Welcome:	June E. Osborn, M.D.
8:40 a.m. - 9:00 a.m.	Overview:	Harlon Dalton
9:00 a.m. - 10:30 a.m.	Understanding a Legacy of Mistrust	
	Presenter:	Mark Smith, M.D., M.B.A.
	Respondents:	Marie St. Cyr, M.S.W. Alpha Thomas Alyce Gullattee, M.D., F.A.P.A.
10:30 a.m. - 10:45 a.m.	BREAK	
10:45 a.m. - 12:15 a.m.	Organizing African American Communities	
	Presenter:	Wilbert Jordan, M.D., M.P.H.
	Respondents:	Sandra McDonald Sonia Singleton Elsie Cofield
12:15 p.m. - 1:30 p.m.	LUNCH	
1:30 p.m. - 3:00 p.m.	Communities Working Together – Pitfalls and Promises of Coalition Building	
	Presenter:	Catlin Fullwood
	Respondents:	Phill Wilson Keith Cylar, M.S.W.
3:00 p.m. - 3:15 p.m.	BREAK	
3:15 p.m. - 4:45 p.m.	Determining What is Culturally Appropriate	
	Presenter:	Rashidah Hassan, RNCIC
	Respondents:	Jacob Gayle, Ph.D. Reggie Williams
4:45 p.m. - 5:30 p.m.	Public Comment	
6:00 p.m.	Reception	- hosted by The Honorable Kurt L. Schmoke, Mayor of Baltimore, and Elias Dorsey, Acting Commissioner of Health

NATIONAL COMMISSION ON AIDS
TECHNICAL BRIEFING
HEALTH CARE FINANCING ISSUES

Peabody Court Hotel
612 Cathedral Street
Baltimore, Maryland

AGENDA

Tuesday, December 18, 1990

8:30 a.m. - 9:15 a.m.

Public Financing

Karen Davis, Ph.D.
Chairman, Department of Health Policy and Management
School of Hygiene and Public Health
The Johns Hopkins University

9:15 a.m. - 9:45 a.m.

Discussion

9:45 a.m. - 10:00 a.m.

BREAK

10:00 a.m. - 10:45 a.m.

Private Financing

Mary Ann Bailey, Ph.D.
Adjunct Associate Professor of Economics and Public Policy
Departments of Economics and Health Care Sciences
The George Washington University and Medical School

10:45 a.m. - 11:15 a.m.

Discussion

11:15 a.m. - 12:00 p.m.

Specific Issues for HIV Disease

Bruce Vladeck, Ph.D.
President
United Hospital Fund

12:00 a.m. - 1:15 p.m.

LUNCH

1:15 p.m. - 1:30 p.m.

Remarks: Hon. Kurt L. Schmoke, Mayor of Baltimore

1:30 p.m. - 3:00 p.m.

Roundtable Discussion about Practical Applications of Financing Mechanisms for HIV Disease

Karen Davis, Ph.D.
Mary Ann Bailey, Ph.D.
Bruce Vladeck, Ph.D.
Penelope L. Pine (HCFA)
Steven Sieverts, M.P.H. (Blue Cross/Blue Shield of the National Capital Area)
Bernard Pont (Field Representative, Social Security Administration)

3:00 p.m. - 3:15 p.m.

BREAK

3:15 p.m. - 4:30 p.m.

Commission Business

4:30 p.m.

ADJOURN

**NATIONAL COMMISSION ON AIDS
TECHNICAL BRIEFING
HEALTH CARE FINANCING ISSUES**

Peabody Court Hotel
612 Cathedral Street
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AGENDA

Tuesday, December 18, 1990

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Discussion

9:45 a.m. - 10:00 a.m.

BREAK

10:00 a.m. - 10:45 a.m.

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Adjunct Associate Professor of Economics and Public Policy
Departments of Economics and Health Care Sciences
The George Washington University and Medical School

10:45 a.m. - 11:15 a.m.

Discussion

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Specific Issues for HIV Disease

Bruce Vladeck, Ph.D.
President
United Hospital Fund

11:45 a.m. - 1:00 p.m.

LUNCH

1:00 p.m. - 2:30 p.m.

**Roundtable Discussion about Practical Applications of Financing
Mechanisms for HIV Disease**

Karen Davis, Ph.D.
Mary Ann Bailey, Ph.D.
Bruce Vladeck, Ph.D.
Penelope L. Pine (HCFA)
Steven Sieverts, M.P.H. (Blue Cross/Blue Shield of the National Capital Area)

2:30 p.m. - 2:45 p.m.

BREAK

2:45 p.m. - 4:00 p.m.

Commission Business

4:00 p.m.

ADJOURN



NATIONAL COMMISSION ON ACQUIRED IMMUNE DEFICIENCY SYNDROME

1730 K Street, N.W., Suite 815
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(202) 254-5125 [FAX] 254-3060

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June E. Osborn, M.D.

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HIV Disease in African American Communities

This hearing is part of a series of deliberations by the Commission focusing on issues surrounding HIV disease in various communities. Each of the Commission's hearings incorporates a broad range of perspectives and issues relevant to different communities. With this hearing, the Commission hopes to build upon this general framework by engaging a specific, focused discussion of some of the critical issues surrounding HIV disease in African American communities.

Objectives

To create a discourse, looking at HIV disease in its larger social context and exploring opportunities for action.

For the Commission to come to a greater understanding of the myriad aspects of HIV disease in African American communities, and to generate relevant policy recommendations.

EXECUTIVE DIRECTOR

Maureen Byrnes, M.P.A.



NATIONAL COMMISSION ON ACQUIRED IMMUNE DEFICIENCY SYNDROME

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EXECUTIVE DIRECTOR

Maureen Byrnes, M.P.A.

Press Release
December 10, 1990

Contact: Thomas Brandt
202-254-5125

Commission to Review HIV Disease in African American Communities; Health Care Financing

The National Commission on AIDS will meet in Baltimore on December 17 and 18 where the discussion the first day will focus on HIV disease in African American communities while the second day will be detailed technical briefings as part of the Commission's long term review of health care financing.

The Monday session is part of the Commission's ongoing series of deliberations on HIV disease in various communities including African American, Hispanic, Native American, Gay and Bisexual and others. It will run from 8:30 a.m. to 5:30 p.m. in Baltimore City Hall, Curran Conference Room, 4th Floor, 100 North Holliday Street. There will be time for public comment starting at approximately 4:45 p.m.

The Tuesday session will be held at the Peabody Court Hotel, second floor, 612 Cathedral Street, and will run from 8:30 a.m. to 2:30 p.m. A copy of the agenda for both days is attached.

-more-

Dr. Osborn, who is Dean of the School of Public Health, University of Michigan, serves on a number of AIDS advisory panels including those for the Global Commission on AIDS for the World Health Organization, the Robert Wood Johnson Foundation, the PEW Charitable Trusts and the Rockefeller Foundation, among others.

Dr. Rogers is also the Chairman of the AIDS advisory panels to the state of New York and to New York City, which has the largest number of persons with AIDS of any city in the United States. He is also the Walsh McDermott University Professor of Medicine at Cornell University Medical College. Dr. Rogers is the former Dean of Medicine and Vice President for Medical Affairs at Johns Hopkins University. For 15 years he was President of the Robert Wood Johnson Foundation.

Members of the Commission were appointed by Democratic and Republican members of Congress and by the President of the United States. They represent a broad array of expertise in medicine, public health, law, public administration, community-based organizations, minority issues and religion.

In addition to Dr. Osborn and Dr. Rogers, there are ten other voting members of the Commission.

0 Diane Ahrens is serving her fourth term as Commissioner of Ramsey County, Minnesota, and is founder of the Tri-County Task Force on AIDS. She is also Chair of the National Association of Counties' Task Force on HIV and AIDS.

0 Rev. Scott Allen is a Baptist minister and Founder of the AIDS Interfaith Network of Dallas.

0 Harlon Dalton is Professor of Law at Yale Law School and author of AIDS and the Law: A Guide for the Public.

0 Eunice Diaz is Assistant Professor of Family Medicine at the University of Southern California Medical School and is an authority on AIDS among Hispanics. She has also served on the Los Angeles County Commission on AIDS, and the Planning Committee for the Surgeon General's Conference on Pediatric AIDS.

0 Donald Goldman is a New Jersey attorney and former president of the National Hemophilia Foundation. He coordinated the Foundation's efforts to improve the safety of the nation's blood supply and many of its efforts to improve hemophilia and HIV service delivery to minorities.

0 Dr. Don C. Des Jarlais is Director of Research for the Chemical Dependency Institute of Beth Israel Medical Center and Deputy Director for AIDS Research with Narcotic and Drug Research, Inc.

0 Larry Kessler is co-founder and Executive Director of the AIDS Action Committee in Boston which is a community-based service organization staffed by 75 full-time employees and more than 1,500 volunteers. He also serves on the Governor's Task Force on AIDS and the Boston Mayor's Task Force on AIDS.

0 Dr. Charles Konigsberg is Director of the Division of Health of the Kansas Department of Health and the Environment. He is the former District Health Program Supervisor and Broward County Public Health Unit Director for the Department of Health and Rehabilitative Services in Fort Lauderdale.

0 Belinda Mason, a former newspaper journalist, was infected with the AIDS virus through a blood transfusion during the birth of her second child. She founded the first organization in Kentucky and Indiana for people with HIV disease and she is the immediate past President of the National Association of People with AIDS.

0 Dr. J. Roy Rowland, one of the few physicians in Congress, is now serving his fourth term in the U.S. House of Representatives representing the Eighth Congressional District of Georgia. He is the prime sponsor of the legislation establishing the Commission.

There are three ex-officio members of the Commission from the President's Cabinet. They are:

0 Richard B. Cheney, Secretary of Defense. Mr. Cheney is the former Chief of Staff to President Gerald Ford, then represented Wyoming in the U.S. House of Representatives from 1979 through 1988.

0 Edward J. Derwinski, Secretary of Veterans Affairs. Mr. Derwinski represented Illinois' Fourth Congressional District in the U.S. House of Representatives from 1959 through 1982, and was a senior State Department official from 1983 to 1989.

0 Louis W. Sullivan, M.D., Secretary of Health and Human Services. Dr. Sullivan was the first Dean and President of the Morehouse School of Medicine.

The Executive Director of the Commission is Maureen Byrnes, who is the former Staff Director to the Chairman and Ranking Member of the Senate Subcommittee on Labor, Health and Human Services, Committee on Appropriations.

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NATIONAL COMMISSION ON AIDS
HEARING
HIV DISEASE IN AFRICAN AMERICAN COMMUNITIES

Curran Conference Room
100 North Holliday Street
City Hall
Baltimore, Maryland

AGENDA

Monday, December 17, 1990

8:30 a.m. - 8:40 a.m.	Welcome:	June E. Osborn, M.D.
8:40 a.m. - 9:00 a.m.	Overview:	Harlon Dalton, Esq.
9:00 a.m. - 10:30 a.m.	Understanding a Legacy of Mistrust	
	Presenter:	Mark Smith, M.D., M.B.A.
	Respondents:	Alyce Gullattee, M.D., F.A.P.A. Marie St. Cyr, M.S.W. Alpha Thomas
10:30 a.m. - 10:45 a.m.	BREAK	
10:45 a.m. - 12:15 a.m.	Organizing African American Communities	
	Presenter:	Wilbert Jordan, M.D., M.P.H.
	Respondents:	Sandra McDonald Sonia Singleton Elsie Cofield
12:15 p.m. - 1:30 p.m.	LUNCH	
1:30 p.m. - 3:00 p.m.	Communities Working Together -- Pitfalls and Promises of Coalition Building	
	Presenter:	Catlin Fullwood
	Respondents:	Phill Wilson Keith Cylar, M.S.W.
3:00 p.m. - 3:15 p.m.	BREAK	
3:15 p.m. - 4:45 p.m.	Determining What is Culturally Appropriate	
	Presenter:	Rashida Hassan, R.N., CIC 15 min
	Respondents:	Jacob Gayle, Ph.D. 10 min Reggie Williams
4:45 p.m. - 5:30 p.m.	Public Comment	
6:00 p.m.	Reception - hosted by The Honorable Kurt L. Schmoke, Mayor of Baltimore, and Elias Dorsey, Acting Commissioner of Health	

255-4659

ASSEMBLY SPEAKER WILLIE L. BROWN, JR.

1388 SUTTER STREET, SUITE 1002

SAN FRANCISCO, CA 94102

DATE: 15 DEC 90

PLEASE DELIVER TO: WENDELL CARMICHAEL

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FROM: B MOORE

(Name)

SFDO

(Office)

OUR FAX NUMBER IS 415/557-8936.

**** If you do not receive all pages or have any problems with receiving, please call 415/557-0784.

COMMENTS:

YOUR COMMENTS ON SURVEY PLEASE!

**WILLIAM J. BRANDY MOORE, MPA
631 FILLMORE STREET
SAN FRANCISCO, CA. 94117
PUBLIC ADVOCACY**

5 December 1990

**TO: AFRICAN AMERICAN HIV/AIDS SERVICE
PROVIDERS**

FR: W.J. BRANDY MOORE, MPA

**RE: AFRICAN AMERICAN AIDS SUPPORT CENTER;
ALSO...QUESTIONNAIRE AND SURVEY**

Attached herewith is a compilation of ideas about residential facilities in San Francisco. It is being sent to you in hopes that you will answer the questionnaire/survey with your concerns and ideas about residential facilities in San Francisco and the Bay area. Later, you will be invited to a meeting to discuss ways by which we can bring some completion to our thoughts about residences for people living with HIV.

Please take this packet home with you and review it over the coming week. Then write down your thoughts and ask yourself, "What steps should be undertaken to create the necessary residences? How much would it cost to "get the job done" well? Lastly, make a commitment to attend a meeting before the end of the year (2-3 hrs., midweek).

QUESTIONNAIRE - SURVEY

RESIDENCES AND SERVICE FACILITIES

FOR AFRICAN AMERICANS WITH AIDS

5 DEC 1990:WJM ACTION 2

Please answer the following questions and return your responses to W J Brandy Moore, Sr. Asst. to Assembly Speaker, 1388 Sutter St., #1002; San Francisco, CA.94109. Fax# 557-8936. These responses will be used to form recommendations for legislation and to assist residence and service providers helping African Americans.

Name (personal or
organizational) _____
Address _____ City/zip _____
Phone# _____ Contact person _____

What residential services are provided by your organization?

Do you provide residence for Medical
clients _____ Is this an important
service for African Americans? Yes _____ No _____

Why? _____

Do you provide emergency residences for African American men

or African American women living with AIDS? Note:

Emergencies include newly diagnosed, evicted or homeless,
head of household w/children, ARC diagnosed, etc.

How would you change the way your organization provides
residence services?

Does your residential service provide individual rooms for
clients? Yes_____ No_____. If so, are there individual
shower and wash-up facilities? Yes_____ No_____. Describe a
model residential facility_____

What can we do to create residential facilities for African
Americans living with AIDS?

Please list your favorite component of a model (demonstration
project) residential facility?

IN 1991.....WE CAN MAKE THIS A REALITY WITH YOUR HELP?!!!!!!

SOCIOCULTURAL FACTORS THAT PREDISPOSE AFRICAN AMERICANS TO HIGH SUSCEPTIBILITY TO HIV INFECTIONS

- **Coexisting Diseases/Conditions (System Stressors)**

- Sickle Cell Anemia
- Heart Disease

African Americans have the highest rates of cardiovascular disease in the world and are 10 times more likely than Caucasians to develop cardiovascular disease

- Hypertension/Stroke

The rate of hypertension (without other heart disease) is 60% higher among poverty groups

- Cancer

African Americans have a higher incidence of cancer than non-minorities and lower survival rates for all cancers

- Tuberculosis

Non-Whites have approximately 5 times the TB incidence of Caucasians

In 1986, 62% of all reported TB cases in the U.S. were among racial/ethnic minorities

African Americans and Hispanics account for 80% of the TB-AIDS cases in New York City, 90% in Florida, and 100% in Newark, NJ

- Cirrhosis of the Liver
- Alcoholism and Drug Addiction

- **Conditions that Result from Socioeconomic Position**

- African Americans have lower incomes and levels of educational attainment than Caucasians

Nearly 50% of African Americans earn less than \$9,999 annually compared to 25% of Caucasians

Nearly 70% of African Americans are high school graduates, compared to 84% of Caucasians

- Inadequate/Inaccessible Health Care

African Americans are less likely than Whites to use an "office-based" physician as their usual source of medical care

African Americans are less likely to seek medical services at early stages of illness

African Americans disproportionately lack medical/health insurance coverage

- Discrimination in Federal and Local Government Programs
- African Americans have Higher Rates of Multiple Nutrition Deficiencies than Caucasians

Nutrition risk related to income limitations regarding quality and quantity of food consumed

Excess prevalence of obesity

- **Extreme Resistance to Condom Use**

- **Denial—Which Underlies Risky Behavior**

- **Inaccurate "Education"/Information About AIDS—Leads to Inappropriate Behavioral Responses to AIDS crisis (e.g., refusing blood transfusions, but continuing to engage in unprotected sex)**



NATIONAL COMMISSION ON ACQUIRED IMMUNE DEFICIENCY SYNDROME

1730 K Street, N.W., Suite 815
Washington, D.C. 20006
(202) 254-5125 [FAX] 254-3060

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EXECUTIVE DIRECTOR

Maureen Byrnes

December 11, 1990

Mr. Reggie Williams
Executive Director
Men of All Colors Together, Inc.
273 Church Street
San Francisco, CA 94114

Dear Mr. Williams:

With the Commission's hearing on *HIV Disease in African American Communities* a week away, I wanted to take this opportunity to provide you with some important information. The agenda, statement of objectives for the hearing, and biographical sketches of the Commissioners are enclosed.

The National Minority AIDS Council and the National Association of Protection and Advocacy Systems are hosting a reception Sunday afternoon at 5:30 p.m. The Honorable Kurt L. Schmoke and the Acting Commissioner of Health, Elias Dorsey are hosting one Monday evening at 6:00 p.m. Invitations to these two receptions are enclosed.

We have asked that the participants meet informally on Sunday so that presenters can share a brief outline of their remarks with the respondents. No formal arrangements have been made to facilitate these meetings. We would ask that the presenters take the initiative to contact the other participants in their session. A list of the participants is enclosed.

We have arranged for you to stay at the Peabody Court Hotel, 612 Cathedral Street. The hotel's telephone number is (800) 732-5301.

Transportation from the Peabody Court Hotel to City Hall has been arranged. A trolley will depart the hotel at 8:00 a.m. Monday morning. If you desire to depart at a different time, taxi service is available.

Please feel free to call if you have any questions about the hearing.

I look forward to seeing you in Baltimore.

Sincerely,

Maureen Byrnes
Maureen Byrnes
Executive Director

MINORITY ISSUES RELATED TO THE HIV ANTIBODY TEST

PREPARED FOR TRESP ASSOCIATES, INC.
BY
SALA UDIN
MULTICULTURAL PREVENTION RESOURCE CENTER
1540 MARKET STREET
SAN FRANCISCO, CA. 94102

MAY 1988

MINORITY ISSUES RELATED TO THE AIDS ANTIBODY TEST

I. PREFACE

The National Institute on Drug Abuse (NIDA) previously commissioned a training course entitled "AIDS and the IV Drug User." Developed by Polaris Research and Development Corporation, one module of the course included an exhaustive resource paper which discussed the technical aspects of antibody testing. That paper has been revised by National Capitol Systems, Inc., also under contract to NIDA, and is presented in this manual as supplemental material.

The purpose of this paper is to focus on antibody testing issues that are unique to minority populations. The paper was written with the assumption that the reader has a basic understanding of the information contained in the above mentioned paper.

II. TESTING -- FOR WHOSE PURPOSES?

The Acquired Immunodeficiency Syndrome (AIDS) is, without a doubt, the most hysteria-laden epidemic in American history. The hysteria is based on innumerable still unanswered questions about HIV and its modes of transmission, and on the fact that persons among whom inordinately high incidence rates have been reported are those whose behaviors fall outside of what many perceived as "normal, moral, healthy, and responsible."

In addition to homosexuals, AIDS is strongly associated with people whose skin is black, brown, red, and yellow. Prior to the epidemic, ethnic minorities openly fought racism on a daily basis, but drug use, homosexuality, anal sex, extramarital sex, etc., were behaviors largely performed "in the closet" -- or at least out of the eyesight and arms reach of "middle-of-the-road" America. Those who dared to venture out of the "closet" (or get caught) were often dealt with harshly and with discrimination, especially if they were persons of hue.

Consequently, the core issue of the antibody testing is the possibility that the positive results, and, by implication, the "forbidden" behaviors, will become public knowledge. Dire consequences can result, which can be harmful to the individual, and his/her family, friends, and significant others.

Great care must be taken by minorities when considering whether or not to take the test, and what should be done following the test. This paper will attempt to highlight some of these important issues.

Although many devotees "worship at the altar of the AIDS antibody test," they are not unified on the most fundamental questions, such as "test for what reasons?" or "toward what end?" Minorities debating whether to undergo HIV antibody testing should clearly distinguish their own personal objectives from those of others.

Conservatives often seek to use the test to identify "criminals" who have broken laws against sodomy, adultery, or drug use. The military and government seek to screen out "undesirables" for those services. Epidemiologists and researchers often advocate for testing as a means of monitoring the growth and direction of the AIDS epidemic. Public health purists seek to quarantine virus carriers and their sex partners. Insurance companies want to use the test results to "screen" persons who should be denied coverage.

On the other hand, many individuals who have engaged in risky behaviors want to know their status for their own edification. Many contend that despite the potential harm that can result from a positive finding, knowledge of positive infection can be a strong motivating force toward safer sex and drug use habits. The individual must examine his decisions regarding testing to determine which of these, or other issues, are the primary motivator for his decision making.

III. FOR WHOM IS MANDATORY TESTING ADVOCATED?

It could have been predicted at the outset of the epidemic that laws requiring mandatory testing would surface. Few observers of the social system were surprised that the groups subjected to mandatory testing are groups in which minorities are over-represented, e.g. prisoners, immigrants, and military and Job Corps inductees, as discussed below.

1. Prisoners

Federal and most State regulations now require that all new inmates be tested for antibodies to the AIDS virus. Those found to be positive are quarantined from the rest of the population regardless of whether they manifest symptoms. The quarantined areas are nearly always bereft of counseling and preventive services.

2. Immigrants

Federal immigration law requires that any person applying for immigration or for amnesty must show evidence that he/she is antibody negative. Persons who test positive are not allowed

citizenship and persons already living in the U.S. who apply for amnesty and test positive face deportation, even if they were infected in the U.S. Frequently, such deportation would be to a country with scarce resources to combat this deadly disease. In addition, since "proof" of negative testing requires identification, any rights to anonymity are lost.

3. Military Recruits

All recruits into any branch of the military must first undergo an HIV antibody test. Persons who test positive are refused entry into the military service. There are no counseling or referral services available to these persons.

4. Job Corps Trainees

The Job Corps is a Federal job training program aimed at inner-city youth. There is an "away-from-home" residential component at Job Corps camp sites. Job Corps trainees are tested before they are allowed admission to the residential facility. Persons who test positive are refused entry into the Job Corps residence and are excused from the Job Corps program. Neither follow-up counseling nor referrals are provided.

IV. OTHER TESTING STRATEGIES

In addition to mandatory testing, the Federal strategy also includes "confidential" testing conducted in community-based facilities, such as drug treatment programs and planned parenthood clinics. These settings are usually called "confidential" rather than "anonymous" because the programs can conduct follow-up or perhaps even "contact tracing". However, there are few guarantees that the recordkeeping methods utilized by these programs will safeguard the identity of those tested and their results.

Private medical labs and clinics have also moved quickly into this still largely unregulated service area by offering "private," confidential, AIDS antibody testing for a fee. These fees can range from \$75 to \$150 dollars for the first test and higher amounts for confirmatory tests. Generally only one test -- the ELISA -- is performed. When performed only once this test is known to have a relatively high rate of unreliability. Again, there are no guarantees that the recordkeeping systems used by these clinics will assure true confidentiality. Further, neither counseling services, education, nor referrals are usually included in the fee. Some of these clinics even notify individuals of their results by mail or telephone.

V. THE NEED FOR COMMUNITY SUPPORT

White gay men who test positive can often expect to return to a supportive, sympathetic, compassionate, non-judgmental white gay

community. The same cannot be said for ethnic minorities whether gay or straight, male or female, adult or child.

Minorities who test positive have very few free or affordable ongoing counseling, social or case management services, unless they are enrolled in a drug treatment program. Consequently, those who advocate for more testing in minority communities must confront a serious dilemma vis-a-vis what can be done about an increasing number of ethnic minorities who are aware of their positive antibody status and who must return to unsympathetic communities with little or no supportive services.

Central to the dilemma is the question of whether persons should be tested if services are unavailable to educate and counsel them about not infecting others and not accelerating their own progression to full blown AIDS.

As stated at the outset, the answer to all these questions must be preceded by an answer to the questions, "testing for what purpose?", "toward what end?", and "in whose interest?"

Admittedly, the AIDS antibody test can be a strong deterrent to continued unsafe sexual and drug using behavior. But as clearly seen in crime prevention, deterrents alone are insufficient. If testing is to be useful for ethnic minorities, it must follow these specific recommendations:

- 1) It must be voluntary, uncoerced by government, bureaucrats, employers, spouses, or anyone else.
- 2) It must be the result of a clear, educated decision by the person being tested who knows exactly what the test is, what it will tell them: a person who has given some thought to who they are going to share the results with and what their emotional reaction is likely to be.
- 3) It must be truly confidential. In most cases this means anonymous. Test sites targeting minorities are always best placed in that targeted ethnic community. Minority communities are often small, closely knit communities in which everyone knows everyone else. Minorities often feel more secure by going to another, perhaps adjacent, community to assure confidentiality.
- 4) The test site need not be labeled as an "AIDS" test site. Often a more general designation, such as "health" or "medical" clinic is more discrete.
- 5) AIDS educational materials used in the test site should, as closely as possible, match the ethnic, cultural, and linguistic character of the targeted populations.

- 6) Most importantly, the staff of the test site should reflect the ethnic, cultural and linguistic needs of the target population. The staff need not be so well known in the community that confidentiality is threatened. But above all, the staff must conduct their work with professionalism, yet with compassion and respect. These are the factors many ethnic minority members look for from bureaucrats and service providers, yet are seldom found.

VI. CONCLUSION

AIDS antibody testing for minorities must be viewed in the context of pre-existing issues of racism, prejudice and discrimination. Added to these factors the more recent hysteria and fear connected to this virus. There are many agendas which must be filtered through so that minorities make wise, self-directed choices about whether or not to be tested and with whom the results will be shared.

Ethnic minorities must be on guard for mandatory testing policies and their potentially harmful consequences if the results are positive. Test sites and test site literature must be culturally appropriate and where possible, culturally matched.

The litmus test for a decision to test should require that the test be voluntary, informed, and confidential.

Personal and Social Consequences
of
Human Immunodeficiency Virus (HIV) Antibody Testing Among
African Americans in the Greater Bay Area

A Special Project

Presented to

Sam Radelfinger, Ph. D., M.P.H.
M.P.H. Advisor

Department of Health Science, San Jose State University

in Partial Fulfillment
of the Requirements for the Degree
Master of Science

by Rama-Selassie Barnwell
May, 1990

PART II - PROPOSAL SUMMARY (150-200 words)

TITLE OF THE PROPOSAL: Personal and Social Consequences of HIV Testing

- Include:
1. Statement of the Problem Hypothesis
 2. Significance of the Project (e.g., Local, National, etc.)
 3. Anticipated Publications/Presentations
-

Previous research indicates that HIV testing is a highly stressful and challenging process for high-risk individuals. Without adequate counseling and social support during the process, testing may not result in appropriate preventive behavior among those at risk (Zones, Beeson, et al., 1989). This request is to conduct supplementary interviews to update and broaden a discussion of issues raised in the earlier research findings on the personal and social consequences of HIV testing among apparently healthy African American men and women at risk of exposure to the AIDS virus.

AIDS is now spreading to large portions of the African American community where health care providers and family counselors and therapists have little experience with the social-psychological and biomedical ravages of the disease in communities of color. While many books and articles discuss various aspects of the AIDS epidemic, none focus primarily on the challenges to individuals in the African American community. This effort will be of assistance to health care providers and counselors in a position to offer guidance and support to individuals at risk. I already have one interested editorial board from HIV Counselor PERSPECTIVES interest in publishing the findings from this project. The article would be read by therapists and HIV counselors. Additionally, the findings from this project will be used as data for a book Dr. Diane Beeson and I plan to write summarizing our combined efforts.

PART III - PROCEDURES/METHODS

- Include:
1. How research will be accomplished
 2. Discussion of project procedures/model
 3. Suggestions for treatment of data
 4. Qualitative quantitative methodology
 5. Proposed dissemination of results
-

The proposed interviews will take place in various communities in the greater Bay area. The interviewer is well-integrated into a large network of AIDS researchers and care providers, and will discuss with them the issues discovered to be important, those they have noted as significant, and ask for referrals that expand or challenge the current research data. Interviewer will meet respondents at the location of greatest convenience to the respondent. Options include the respondent's home, coffee shops or, for maximum privacy and anonymity, the respondents' or interviewers' automobile, all of which have been requested by respondents in the past.

Respondents will be interviewed using the interview guide used during the original study. The interview guide is designed to allow interviewees to formulate their experiences and concerns in their own language with minimal structuring by the interviewer. At the same time the interviewer will attempt to direct attention to certain broad areas of concern. Respondents included in these interviews will be referred by health care workers, community leaders and other involved in HIV-related services to the African American community.

The outcome of the proposed project is an article that will provide a descriptive summary of the range of respondents to HIV testing in a sampling of the African American community at risk for HIV infection. The article will be directed toward health care providers, health educators, counselors and family therapists. The purpose of this article is to alert professionals and interested lay persons to the social-psychological process and issues involved in testing so that they can provide optimal counseling and support to individuals at risk, thereby strengthening prevention efforts. Because treatment is rapidly improving, and because AIDS is making increasingly rapid inroads into communities of color, some of the issues that will be addressed in this proposal merit expanded examination.

Interview Guide

(The goal is to have the interview describe his or her experiences related to HIV testing with as little semantic structuring as possible by the interviewer. The following questions may be asked if necessary to make sure that basic issues are covered.)

1. When and how did you first become concerned about your personal risk for AIDS?
2. How did you decide to be tested? Who or what influenced you in this process?
3. When and where were you tested? What was your test result?
4. What was the experience like at the testing site? How helpful was the counseling you received?
5. What are the consequences of learning your antibody status?
6. Have you changed any of your behavior because of the threat of AIDS, or because of your test results?
7. Whom have you told about your test results? What were their reactions?
8. What do you do to protect your self/partner(s) from exposure to AIDS?
9. What do you find most difficult about changing your sexual (or other high-risk) behavior?
10. What difficulties have you encountered as a result of being infected with HIV?
11. What have been the consequences of learning your test result?
12. What is difficult about being Black/Gay/Straight/female and being infected with HIV?
13. What advice would you give to others considering being tested for exposure to HIV?
14. What has been important about this issue that we have not discussed?

PERSONAL AND SOCIAL CONSEQUENCES OF HIV ANTIBODY TESTING

CONSENT TO BE INTERVIEWED

Purpose and Background:

Rama-Selassie Barnwell, a graduate student in public health under the supervision of Dr. Diane Beeson, medical sociologist, is conducting a series of interviews to supplement and update earlier findings about the needs and concerns of individuals at risk for HIV infection. As a person who has considered HIV testing, or been tested, I am willing to share my experience on this matter with Rama, and permit him to tape record the interview. The purpose of this interview is to find out how testing affects people's lives and relationships.

Risk:

The risks to me of participating in this study include the possibility of emotional discomfort as a result of discussing a sensitive topic.

Benefits:

There will be no direct benefit to me except that factual misunderstandings regarding HIV may be clarified, or I may learn about services available to people at risk which I was not previously aware of.

Confidentiality:

Any identifying information I have provided will not be attached to tape-recorded or written records of my interview. Tapes will be destroyed as soon as they are transcribed. The information I provide will be kept as confidential as possible under the law and neither my name nor other information which could be used to identify me will be used in any published reports of this research project.

Participation is Voluntary:

I have the right to end the interview at any point and to refuse to answer any questions that are uncomfortable or embarrassing for me to answer.

Date: _____ Signature: _____

AFRICAN-AMERICAN MEN AND AIDS
CONFERENCE PRE-TEST

CITY San Francisco, California DATE December 8, 1989

=====

PART 1 - Tell us about yourself.

(2-3)

(4-6)

1. With what type of organization are you affiliated?
(Please circle all that apply to YOU)

- | | |
|---|------------------------------------|
| 1 - Drug & Methadone Treatment Provider | 11 - Hospital Based |
| 2 - IVDA Counselor/Therapist | 12 - Police Officer |
| 3 - Black Community Based Organization | 13 - Criminal Justice |
| 4 - Private Agency | 14 - Probation |
| 5 - Federal Agency | 15 - Corrections |
| 6 - State Agency | 16 - Social Services |
| 7 - County Agency | 17 - Counseling Center |
| 8 - City/Municipal Agency | 18 - Education |
| 9 - Military | 19 - Student |
| 10 - Public Health | 20 - Other (Please describe) _____ |

2. What is your professional status? (Circle all that apply)

(7-8)

- | | | | |
|---------|---------|--------------|-----------------------------|
| 1 - MD | 4 - MPH | 7 - NP | 0 - Clergy |
| 2 - PhD | 5 - RN | 8 - DDS | X - Other (Please describe) |
| 3 - MSW | 6 - LVN | 9 - Educator | |

3. What sex are you? 1 - Male 2 - Female

(9)

=====

TRUE/FALSE INSTRUCTIONS: Please circle T if the statement is True, F if the statement is False.

- | | | |
|--|-------|------|
| 4. All lab specimens should be handled as potentially infectious. | T F | (11) |
| 5. According to the Center for Disease Control, blood, semen and vaginal secretions have been implicated in HIV transmission. | T F | (12) |
| 6. The majority of African-American adults with AIDS in the U.S. acquired the infection through homosexual/bisexual contact. | T F | (13) |
| 7. People with AIDS usually die from opportunistic infections. | T F | (14) |
| 8. If accidentally contaminated with a patient's blood or body fluids, the first step to take is report the incident to your supervisor. | T F | (15) |
| 9. AIDS (HIV) can be spread by sharing needles when "shooting up" drugs. | T F | (16) |

(Please go on to the next page)

(ABM)

MULTIPLE CHOICE INSTRUCTIONS: Please circle the ONE best response for each statement.

10. Seropositivity to the HIV antibody test means that:

- 1 - The person will get AIDS (23)
- 2 - The person has AIDS
- 3 - The person has protective antibodies against HIV
- 4 - The person has been exposed to HIV and produces marker antibodies

11. Of the reported AIDS cases in the U.S. approximately 25% are:

- 1 - Under age 13 (25)
- 2 - Black
- 3 - Asian
- 4 - Women

12. The reason for increased risk of AIDS in Prison is:

- 1 - Increased risk of homosexual rape (27)
- 2 - Lack of available resources needed for safe sex
- 3 - Lack of access to clean needles
- 4 - All of the above

13. A common sign/symptom of AIDS in infants is:

- 1 - Failure to thrive (29)
- 2 - Lymphopenia
- 3 - Dementia
- 4 - Kaposi's sarcoma

14. Why are prostitutes at high risk for AIDS? (30)

- 1 - They refuse to use condoms.
- 2 - They have multiple unknown sex partners.
- 3 - They are always intravenous drug users (IVDU's).
- 4 - Both 1 and 2.
- 5 - All of the above.

15. In order for African-American men to change their high risk sexual behavior, which one of the following factors is the most important? (31)

- 1 - Knowledge of AIDS risk behaviors
- 2 - Knowledge of condom use
- 3 - Belief that they can follow safe sex guidelines
- 4 - None of the above

16. What is the main strategy in which African-American men can increase their ability to have safe sex with their partners? (32)

- 1 - Learn how to physically identify sexual partners who only practice safe sex
- 2 - Develop the communication and social skills to negotiate safer sex
- 3 - Develop a monogamous relationship with their sexual partner
- 4 - All of the above

17. Which of the following must occur to increase the practice of safe sex among men in African-American communities. (33)

- 1 - Condoms must be given to all sexually active African-American men
- 2 - All African-American men must have a high level of knowledge about AIDS
- 3 - Social norms must develop which oppose unsafe sex in the community
- 4 - None of the above

18. African-Americans are at greater risk of AIDS because..... (34)

- 1 - There are more economically deprived people within this group and they do not seek health care readily.
- 2 - The AIDS virus is easily contracted by ethnic and racial populations.
- 3 - IV Drug use is high among these groups.
- 4 - None of the above.

TRUE/FALSE INSTRUCTIONS:

Please circle T if the statement is True, F if the statement is False.

- 19. AIDS stands for Acquired Immune Deficiency Syndrome. T F (41)
- 20. HIV stands for Homosexual Infection Virus. T F (42)
- 21. HIV is the virus that causes AIDS. T F (43)
- 22. The use of latex condoms and spermicide is recommended as a barrier against the spread of HIV. T F (44)
- 23. The spread of AIDS (HIV) can be prevented by hand-washing before and after patient care and by wearing gloves when handling patients' body fluids. T F (45)
- 24. Exclusively heterosexual men do not get AIDS. T F (46)
- 25. Needles and syringes should be disposed of without breaking or recapping the needles. T F (47)

Thank You!!

COUNTY-WIDE CONFERENCE

AFRICAN-AMERICAN MEN AND AIDS

For health care providers, counselors and other staff professionals who work with African-American Men.

A SURVEY ON AIDS KNOWLEDGE, ATTITUDES AND BEHAVIOR

CITY San Francisco, California DATE December 8, 1989

PART 1 - Tell us about yourself.

(2-3)

(4-6)

1. With what type of organization are you affiliated?
(Please circle all that apply to YOU)

- | | |
|---|------------------------------------|
| 1 - Drug & Methadone Treatment Provider | 11 - Hospital Based |
| 2 - IVDA Counselor/Therapist | 12 - Police Officer |
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| 4 - Private Agency | 14 - Probation |
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| 7 - County Agency | 17 - Counseling Center |
| 8 - City/Municipal Agency | 18 - Education |
| 9 - Military | 19 - Student |
| 10 - Public Health | 20 - Other (Please describe) _____ |

2. What is your professional status? (Circle all that apply)

(7-8)

- | | | | |
|---------|---------|--------------|-----------------------------|
| 1 - MD | 4 - MPH | 7 - NP | 0 - Clergy |
| 2 - PhD | 5 - RN | 8 - DDS | X - Other (Please describe) |
| 3 - MSW | 6 - LVN | 9 - Educator | |

3. What clientele do you serve? (Circle all that apply)

(10-11)

- | | |
|---|----------------------------|
| 1 - Black women of childbearing age | 7 - Military/veterans |
| 2 - Other women of childbearing age | 8 - Children/infants |
| 3 - Clients in drug/methadone treatment | 9 - Teens/young adults |
| 4 - Hospital/health oriented | 0 - Adults/elderly |
| 5 - AIDS patients | X - Families/dysfunctional |
| 6 - Agencies dealing with AIDS patients | Y - General public |
| Z - Other (Please describe) _____ | |

4. What is your ethnic or racial background? (Circle one only)

(13)

- | | | |
|----------------------------|-------------------------|---------------------|
| 1 - Black/African-American | 3 - Mexican American | 5 - Native American |
| 2 - White/Caucasian | 4 - Hispanic, not White | 6 - Asian American |

- X - Other (Please describe) _____

5. Please indicate your sex? 1 - Male 2 - Female

(14)

6. What is your age? _____

(15)

(Please go on to the next page)

PART 2 - AIDS - Information.

7. If you wanted more specific information about HIV infection, where would you get it? (Circle all that apply)

1 - Medical Society (17)
2 - Public Health Department
3 - Local Medical Library
4 - AIDS Hot Line
5 - Centers for Disease Control

8. Which ONE of the following sources are you most likely to use to obtain HIV/AIDS treatment and prevention information?
(Circle ONE only)

1 - Medical Society (19)
2 - Public Health Department
3 - Local Medical Library
4 - AIDS Hot Line
5 - Centers for Disease Control

9. Do you agree or disagree with this statement:
"To be effective, AIDS education must lead to change in behavior."

1 - Strongly agree (21)
2 - Somewhat agree
3 - Not sure
4 - Somewhat disagree
5 - Strongly disagree

10. Do you agree or disagree with this statement:
"Reliable and pertinent data on the incidence of HIV-1 infection are relatively sparse within the health care community."

1 - Strongly agree (23)
2 - Somewhat agree
3 - Not sure
4 - Somewhat disagree
5 - Strongly disagree

11. Do you agree or disagree with this statement:
"The feeling conveyed to the public from responsible health officials about AIDS is ambivalent."

1 - Strongly agree (25)
2 - Somewhat agree
3 - Not sure
4 - Somewhat disagree
5 - Strongly disagree

(Please go on to the next page)

PART 3 - AIDS -Testing and Infection.

12. Have you ever been tested for HIV?

- 1 - Yes (27)
- 2 - Yes in blood donation/transfusion
- 3 - No
- 4 - No, I am not at risk for infection

13. Do you plan to be tested for HIV during the next 12 months?

- 1 - Already have been tested (29)
- 2 - Yes
- 3 - No
- 4 - Never thought about being tested
- 5 - Not sure

14. What do you believe your chances are of getting infected with HIV?

- 1 - High (a greater than 60% chance) (31)
- 2 - Somewhat high (41% - 60% chance)
- 3 - Somewhat low (21% - 40% chance)
- 4 - Low (a less than 20% chance)
- 5 - None (0% chance of HIV infection)
- 6 - Not sure

15. The U.S. Public Health Service has said that AIDS is one of the major health problems in the country, but exactly how many people it affects is not known. The Surgeon General has proposed that a study be conducted and blood samples be taken to help find out how widespread the problem is. If you were selected as a member of this national sample of persons to have their blood tested with assurances of privacy of test results, would you have the test?

- 1 - Yes, definitely (33)
- 2 - Yes, probably
- 3 - Not sure
- 4 - No, probably not
- 5 - No, definitely not

16. Do you agree or disagree with this statement:

"The degree of risk of HIV infection to the majority of Americans is a matter of debate."

- 1 - Strongly agree (35)
- 2 - Somewhat agree
- 3 - Not sure
- 4 - Somewhat disagree
- 5 - Strongly disagree

17. Do you agree or disagree with this statement:

"For the most part, those who will develop AIDS in the next five years have already been infected with HIV-1."

- 1 - Strongly agree (37)
- 2 - Somewhat agree
- 3 - Not sure
- 4 - Somewhat disagree
- 5 - Strongly disagree

THANK YOU!!!