

HRSA Care *ACTION*

PROVIDING HIV/AIDS CARE IN A CHANGING ENVIRONMENT

HIV/AIDS in Racial and Ethnic Minorities

Racial and ethnic minorities comprise approximately 27 percent of the U.S. population, but account for more than 66 percent of the Nation's new AIDS cases reported in the year ending June 30, 1998.¹ Available data indicate that a growing proportion of the estimated 40,000 new HIV infections each year are among racial and ethnic minorities.²

By the year 2030, it is projected that racial and ethnic minorities will comprise 40 percent of the total U.S. population. Currently, these individuals have less access to health care, and therefore poorer health status than Whites.³ The future of the Nation is greatly

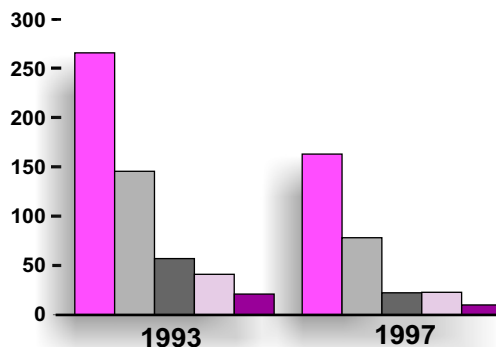
influenced by the health of all citizens.³ Unless the circumstances that result in health disparities among some segments of the population are addressed, the health status of the American public will continue to erode, individuals and families will suffer, and the Nation will be deprived of contributions it can ill afford to lose.

The circumstances of those at high risk of HIV infection must determine prevention and care strategies. Yet, defining group characteristics and needs is complicated by tensions surrounding the issues of

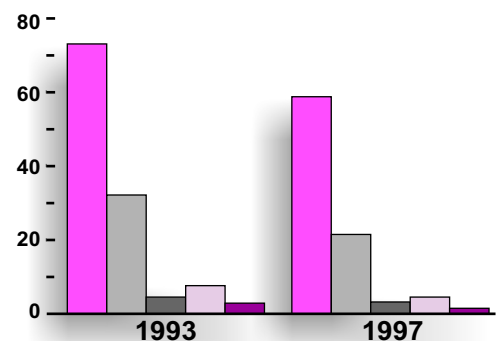
Continued on Page 2

AIDS Cases Per 100,000 Persons By Race, 1993 and 1997

Adolescent and Adult Males



Adolescent and Adult Females



Black	266.2	163.4	73.1	58.8
Hispanic	145.9	78.5	32.2	21.5
White	57.3	22.5	5.0	3.0
American Indian/Alaska Native	41.3	23.0	7.7	4.7
Asian/Pacific Islander	21.2	10.2	2.9	1.5

Source, CDC, Surveillance Reports, 1993-1997

race and poverty. The Nation can only stem the tide of new infections—and improve life outcomes for those living with the disease—by matching prevention messages and health services with the needs of particular groups in effective and appropriate ways.

Surveillance Data

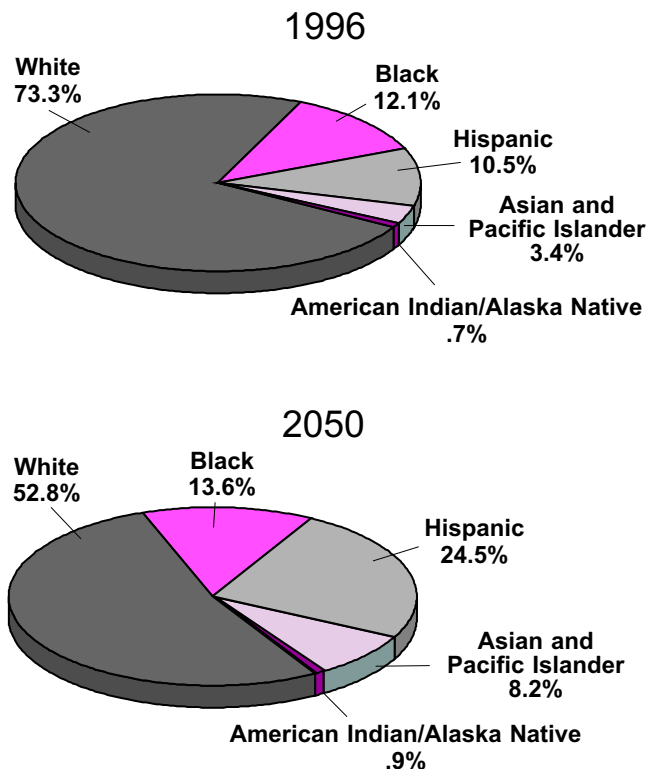
In the first quarter of 1996, the number of new AIDS cases among Blacks exceeded the number among Whites for the first time. Blacks and Hispanics accounted for 67 percent of persons diagnosed with AIDS between June 1997 and June 1998.²

Due in large part to the beneficial effects of new treatment regimens, numbers of people newly diagnosed with AIDS began to decline in 1996. The decrease is smaller for women than men, and smallest overall for Blacks and those infected through heterosexual contact. AIDS deaths declined 42 percent between 1996-1997; decreases were greater among men than women, and greatest among Whites and men who have sex with men.²

Women of Color

Over the past decade, the epidemic has increased most dramatically among women of color. Black and Hispanic women represent less than 25 percent of U.S. women, yet comprise 80 percent of females' AIDS cases reported in the year ending June 30, 1998.

**Total U.S. Population
(In Millions)**



Source, US Bureau of the Census, 1996

***HAB Launches Newsletter Series on
HIV/AIDS in Minority Populations***

In this edition of *HRSA Care ACTION*, the HIV/AIDS Bureau publishes the first of three sequential issues on HIV/AIDS in minority populations.

- | | |
|------------------------|--|
| Issue 1, February 1999 | HIV/AIDS in Minorities Overview
Men Who Have Sex With Men of Color |
| Issue 2, March 1999 | HIV/AIDS Among Hispanics
HIV/AIDS Among Men of Color Whose Risk Factor is IDU or Heterosexual Contact |
| Issue 3, April 1999 | HIV/AIDS Among Women of Color
HIV/AIDS Among African American Young Females
HIV/AIDS Among Asian and Pacific Islanders
HIV/AIDS Among American Indians and Alaska Natives |

Back issues of *HRSA Care ACTION* are available through the HIV/AIDS Bureau website, <http://www.brsa.dbhs.gov/hab>, or by calling Helena Young at 301-443-6652.

The needs of women with HIV/AIDS are shaped, in part, by the fact that almost two-thirds are mothers of children under 20 according to CDC estimates. Young and minority women also are disproportionately affected by sexually transmitted diseases (STDs), e.g., gonorrhea, syphilis and chlamydia, which make women two to five times more vulnerable to HIV infection.⁴

Many women are unaware of their own or their sexual partners' serostatus. Moreover, the epidemic among women is complicated by the intersection of HIV and injection drug use (IDU). The majority of AIDS cases in women is transmitted through IDU or heterosexual contact with an IDU. (See: *HRSA Care ACTION*, "Women and HIV/AIDS" December 1998, and "Substance Abuse and HIV/AIDS," April 1998.)

Men of Color Men of color account for a highly disproportionate number of AIDS cases reported from July 1997 - June 1998. Of cases among men, White men accounted for 37 percent, while Blacks and Hispanics made up 39 percent and 21 percent, respectively. Unidentified or unreported risk is substantially higher for Blacks, Hispanics and Asian/Pacific Islanders than for White or American Indian/Alaska Native men.²

Men of Color who have Sex with Men For the year ending in June 1998, men who have sex with men (MSM) was cited as the exposure category for 45 percent of men diagnosed with AIDS. During the same year, MSM accounted for 31 percent of AIDS cases among Black males, 34 percent among Hispanics, 60 percent among Asian/Pacific Islanders, and 45 percent among American Indian/Alaska Natives.² For HIV infections reported in the year ending in June 1998 by those States with integrated HIV reporting systems, MSM is the largest exposure category for all populations except Black men, for whom "unreported/unidentified risk" represents 48 percent of new infections.²

AIDS incidence among White MSM has declined each year since 1993. Among Blacks and Hispanic MSM, it continued to increase until 1996. The declines since then have not been as significant among minority MSM as for Whites.⁵

Men of Color who Inject Drugs Injection drug users represent 22 percent of male AIDS cases reported in the year ending in June 1998. IDU is significant among several minority groups, accounting for 28 percent of new AIDS cases in Black men, 29 percent in Hispanic men, and 19 percent in American Indian/Alaska Native men.

Adults below age 25 Individuals ages 13-24 accounted for 4 percent of AIDS cases and 15 percent of HIV infections reported from June 1997 through June 1998. Through June 1998, almost 60 percent of cumulative AIDS cases reported in 13-24 year-old males were among Blacks and Hispanics (36 percent and 21 percent). In females between the ages of 13 and 24, more than 75 percent of cumulative AIDS cases are among Blacks and Hispanics (57 percent and 20 percent). Adolescent females are at higher risk for HIV/STD infection than adults because they tend to have multiple sex partners and are less likely to practice safer sex.⁴ Young women of color are more likely to suffer from STDs, be poor, undereducated and lack access to health services than young White women.

Young men who have sex with men remain at increased risk of infection. In 1997, around one-half of the male HIV diagnoses in men aged 13-24 were attributed to male-to-male sex. In a study of young MSM from six urban U.S. counties presented at the XI International Conference on AIDS, Valleroy, et al. found that between 5-9 percent were already infected with HIV; a higher percentage of Blacks and Hispanics were infected than Whites.⁵

Infants and Children of Color More than 80 percent of cumulative pediatric AIDS cases (those under age 13) are among Blacks and Hispanics. Black children made up more than 59 percent of the pediatric AIDS cases reported between June 1997-June 1998. During the same period, Hispanic children made up 22 percent of pediatric AIDS cases.

Between 1996-97, the number of children diagnosed with AIDS declined 40 percent, but the decrease was less for Hispanics than for Whites and Blacks. This decrease primarily reflects successful efforts to reduce perinatal transmission through voluntary AZT therapy during pregnancy and labor. The decline indicates the significance of early prenatal care and HIV testing for pregnant women as well as the importance of health care access.

Co-Morbidity

The racism and its associated problems of poverty, disenfranchisement from social institutions, and lack of access to health care encountered by many individuals of color are reflected in higher incidences of co-morbidity among minorities. Rates of cancer, heart disease, diabetes, homicide, unintentional injuries, and infant mortality are higher for minorities, while immunization rates are lower.⁶ Blacks are four to

Continued on Page 4

eight times more likely to have TB than Whites. Co-morbidity complicates the life of the patient and therefore can compromise the individual's ability to make healthy decisions, to respond to prevention messages, to access health services, and to comply with treatment regimens.

Substance abuse is strongly linked to the AIDS epidemic.^{***} Injection drug use hastens the spread of HIV/AIDS through infection from shared "works" and unprotected sexual activity with and among IDUs. IDU is particularly significant among heterosexual men living with HIV. The spread of HIV in women closely parallels its spread among IDUs. Female substance abusers face additional reproductive health

problems, as they are less likely to have used contraceptives (including condoms) in the past year and are more likely than their non-addicted peers to experience pregnancy, abortion, childbirth and STDs.⁸ Non-injection drug use is known to negatively influence safe sex choices and the ability of the HIV-infected individual to seek and adhere to medical treatment.

People with substance abuse histories are less likely to be employed and frequently lack health coverage, which provides care and improves health outcomes. These individuals require special interventions, which combine health services with confidential and accessible drug abuse treatment and counseling.

Congressional Black Caucus Announcement

Last October, the Clinton Administration declared HIV/AIDS in racial and ethnic minority communities a severe and ongoing health crisis. The Department of Health and Human Services, in collaboration with the Congressional Black Caucus, announced a new \$156 million Initiative to address this crisis through increased funding and outreach to these communities. The CBC Initiative targets HIV/AIDS in three specific areas: technical assistance and infrastructure support; increasing access to prevention and care; and building stronger linkages to address the needs of specific populations.

Ryan White CARE Act-funded programs received \$12 million in new program funds under the CBC Initiative. The breakdown of these funds is as follows:

\$5 million supplement to Title I (awards made in December 1998)

\$3 million addition to Title III

\$2 million addition to Title IV

\$2 million to fund AETC/HBCU clinical training on the new HIV/AIDS treatment guidelines

The \$3 million under Title III will fund additional planning grants to help build HIV primary care capacity of indigenous organizations serving African American populations. Approximately 60 planning grants are expected to be awarded under the African American Populations Initiative. Indigenous nonprofit organizations serving African American Populations are strongly encouraged to apply for funding. A portion of the \$3 million (\$943,000) also will fund 19 planning grants to support applicants in rural or underserved areas where emerging or ongoing HIV primary health care needs have not adequately been met.

Application kits (including program guidance), for the CARE Act Title III HIV Planning Grant Program (CFDA #93.918B), are available from the HRSA Grants Application Center, 1-888-300-HRSA. Pre-application technical assistance workshops also are being offered; registration information may be obtained from Jason Linkins at 703-852-2927. Dates, times and locations of workshops are listed in this month's *HRSA Care ACTION* calendar.

Potential grantees who have additional questions may call the Primary Care Services Branch, HIV/AIDS Bureau, at 301-443-0735.

Mental illness can severely reduce the ability to protect oneself from HIV infection and to access appropriate treatment. Mental illness decreases the ability to make healthy behavior changes, weakens protective behaviors and inhibits access to and compliance with appropriate treatment. The mental health needs of minorities are not adequately being met, due in part to their lower levels of health insurance and income.⁹

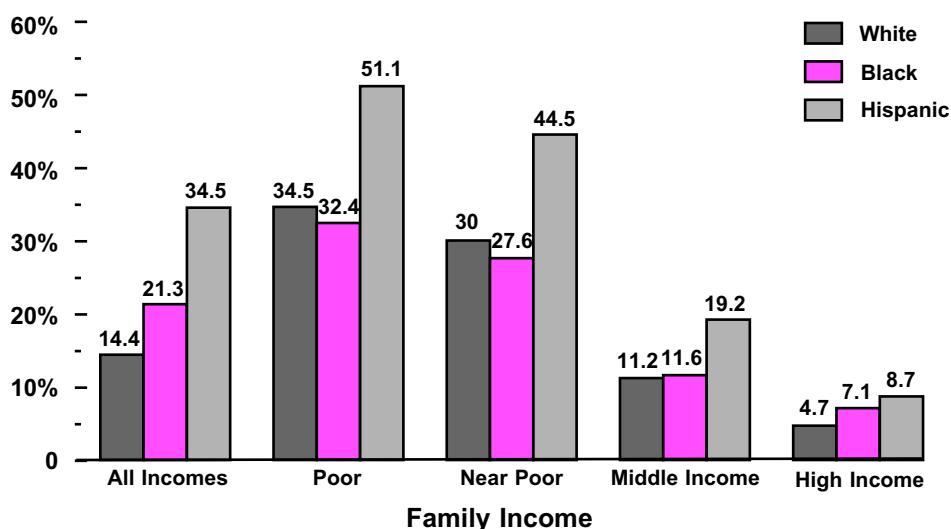
A healthy sense of self-esteem often is required in order to refuse sex or drugs; to negotiate safer sex and condom use; and to seek testing, counseling, and treatment.¹⁶ The depression and isolation caused by poverty and lack of opportunity may cause individuals to seek approval by engaging in high risk behaviors, including unprotected intercourse. Many people — both men and women—lack the self-efficacy to negotiate condom use and safer sex. The implications for being tested and staying in treatment are clear."^{11,12,13}

Economic and Social Issues

Economic Inequality The Federal Office of Minority Health has determined that increased economic inequality is the driving force behind the rising health disparities among Americans.¹⁴ In one study of minorities, 63 percent of respondents reported that medical costs and transportation were the greatest barriers to health care.¹⁵ Minorities are more likely to be low income than are Whites. Poverty is a particular issue for women of color: the majority of minority households headed by working women have incomes below the Federal poverty level, according to research from the National Institutes of Health.¹⁶

Socioeconomic status impacts not only an individual's access to and use of health care, but also the quality of and benefits derived from health care. For example,

Adults 18 to 64 Years of Age with No Health Insurance: 1994-1995



Source, CDC, National Center for Health Statistics, National Health Interview Survey, 1994-1995

Note: The numbers in other racial groups-Asian Pacific Islander and American Indian/Alaska Native-are not sufficient to calculate reliable estimates.

People were declared as uninsured if they did not have any of the following types of health insurance coverage: private health insurance, Medicare, Medicaid, other public assistance, CHAMPUS, or military coverage.

Family income categories are based on family income and family size using poverty thresholds developed by the U.S. Bureau of the Census.

Poor people have family incomes below the Federal poverty level. For a family of four, the Federal poverty level was \$15,569 in 1995.

Near Poor people have family incomes between 100 and 199 percent of the Federal poverty level.

Middle income people have family incomes at least 200 percent of the Federal poverty level, but less than \$50,000.

High income people have family incomes at least 200 of the Federal poverty level, and at least \$50,000.

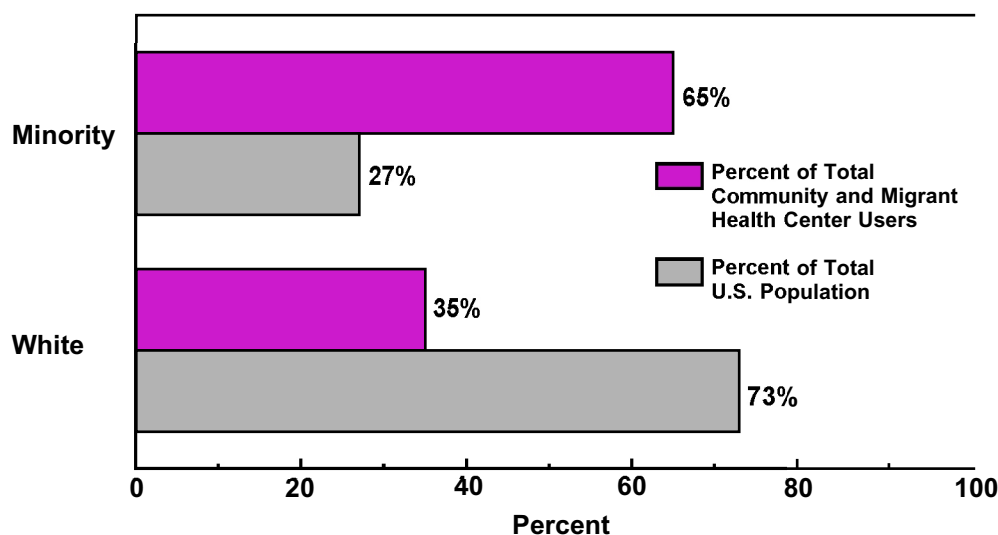
one study found that women with incomes under \$10,000 are almost two-thirds less likely to be prescribed protease inhibitors than those with higher incomes.¹⁷

Impoverished communities have higher numbers of homeless individuals. Homelessness, in turn, increases risk for HIV due to associated high rates of substance abuse, prostitution and survival sex (exchanging sex for shelter, food, or money).

Insurance Minorities are less likely to have health coverage than Whites. At every income level, Hispanics are less likely to be insured than other racial/ethnic groups. In 1994-95, 34.5 percent of

Continued on Page 6

Racial and Ethnic Distribution in Underserved Areas Compared to the General Population: 1997



Source: Health Resources and Services Administration (HRSA), Bureau of Primary Health Care Uniform Data System, 1997, U.S. Bureau of the Census, Current Population Reports, 1998

Hispanics aged 18-64 were uninsured, compared to 21 percent of Blacks and 14 percent of Whites. The same year, 17 percent of Hispanic adults with a health problem had not seen a physician in the previous year, compared with 13 percent of Blacks and 11 percent of Whites. Hispanic children were more than twice as likely as White children to lack health insurance; Black children were almost 20 percent more likely to be uninsured than White children.⁶

Minorities spend a greater portion of their income on health services and are more likely to live in medically underserved areas than Whites. Minority representation in medically underserved areas is almost three times these groups' representation in the general population. Many minorities who are economically disadvantaged lack "sick leave," and may risk job loss if they make frequent trips to the doctor. Current recipients of public assistance benefits face time limits that curtail their social support and health benefits; work requirements place them in jobs without employer-sponsored health benefits.^{6, 18}

Access to Qualified HIV/AIDS Care The provider's level of experience and expertise in HIV/AIDS medicine contributes markedly to the patient's health. Yet, medically underserved communities

often lack HIV/AIDS specialists. For people living with AIDS, long-term survival is related to the individuals' opportunistic infections and how these infections are treated, the overall quality of medical care, prescription of protease inhibitors, and the availability of antiretroviral therapy and prophylactic drugs.¹⁸

Minorities are less likely to receive protease inhibitors than Whites, regardless of their ability to pay for services. In one study, more than 60 percent of Whites and U.S.-born Hispanics were prescribed protease inhibitors, compared to only 46 percent of foreign-born Hispanics and 31 percent of Blacks. Low-income people are less likely to receive protease inhibitor prescriptions: women who received care at a private facility were

seven times as likely to report protease inhibitor prescriptions than women receiving health care at public facilities.^{17, 19} (See also results of the HIV Cost and Services Utilization Study showing disproportionate care patterns for HIV among African Americans, *New England Journal of Medicine*, December 24, 1998.)

Another study found that 58 percent of eligible Black patients received antiretroviral therapy, compared to more than 80 percent of eligible White patients. Researchers controlled for ability to pay, income, insurance type, and place of residence, and found race to be the only documented difference between patients.²⁰ Minorities with AIDS are less likely than Whites to know their viral load and their need for medical treatment, and more likely to make treatment decisions based on little or poor information. For HIV-positive people, such a lack of information is devastating.^{21, 22}

Education Educational level may have a large effect on the overall survival of people living with AIDS. Numerous studies have examined the relationship of education to AIDS mortality. Data show that males with high school or less education were almost twice as likely to die of HIV-related conditions than those

with more education. For women, females with high school education or less were approximately six times more likely to die of HIV-related conditions than those with more education.^{23, 10}

Access to Information Knowledge about preventive behaviors and awareness of the need to practice them is critical.⁴ Unfortunately, these messages may not be reaching minority communities most in need: minorities are more likely to lack accurate information about HIV than Whites. Recent National Health Interview surveys found that almost 25 percent of Black adults felt they knew "little or nothing" about HIV/AIDS, compared to less than 10 percent of White adults; Blacks were more likely to believe myths about casual contact, less likely to believe in condom efficacy, and less aware of drugs for treating HIV disease.²⁴

For many, HIV/AIDS is one in a series of pressing health and socio-economic issues. To individuals without insurance or access to affordable health services, who feel isolated and have trouble paying their bills, HIV infection is not necessarily their most immediate short-term concern. Effective HIV/AIDS services must be accessible, flexible, and user friendly. Interventions must be customized and tailored to meet the particular needs of different groups, and should recognize and address specific barriers.

Cultural Issues Discrimination faced by people of color and by lesbian, gay, bisexual and transgendered individuals creates barriers to effective prevention, intervention, and care. Denial of the threat of AIDS and the prevalence of risk factors also places communities at risk. For example, denial of homosexuality inhibits a community's ability to implement effective HIV/AIDS prevention and education campaigns. It also increases MSM's isolation and reluctance to seek care and discuss their risk factors with providers.⁵

Cultural Competency Research indicates that some individuals are reluctant to seek care because they mistrust the system, face language or other cultural barriers, or have felt mistreated by culturally uninformed individuals and organizations. Racial and

cultural background profoundly affects an individual's ability to establish an effective therapeutic relationship. Health care programs must be culturally competent if they are to be effective. Cultural competency helps ensure that education, prevention, research, and care reach the community in need. A culturally competent provider is aware and respectful of cultural differences and how the client's culture affects beliefs, norms, values, attitudes, and behaviors about health issues, including HIV/AIDS.⁹

Conclusion

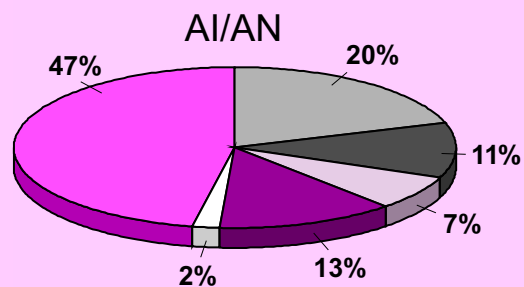
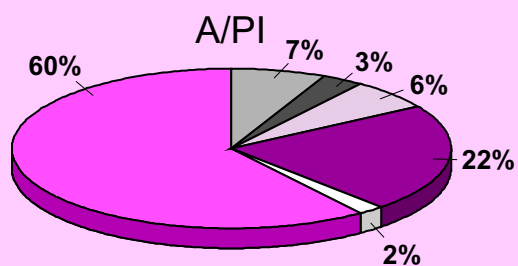
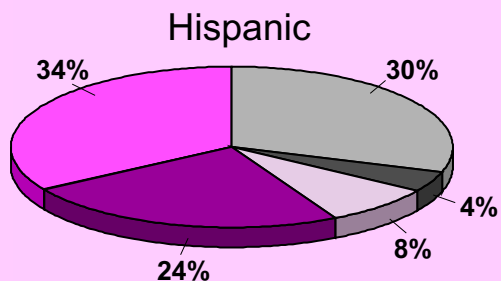
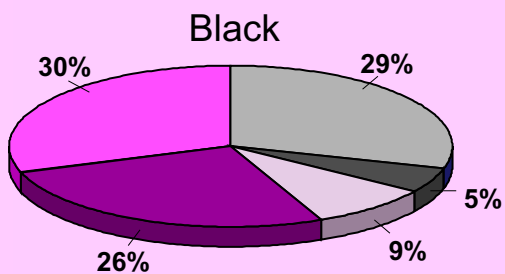
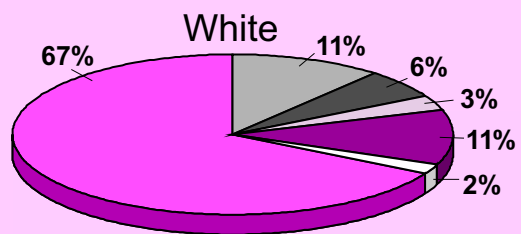
In order to effectively stem the spread of HIV among minorities and improve the health care of those already infected, prevention and intervention programs must specifically address the unique needs faced by the various segments at high risk for HIV infection. Individuals often face not only the trauma of addressing their HIV status, but also other health difficulties such as poor physical health, mental illness, substance abuse, and poor nutrition. Tertiary complications such as level of acculturation, language barriers, lack of transportation, and poverty also inhibit effective services for people living with HIV/AIDS.

A one-size-fits-all approach to these multiple problems will not work. Research increasingly reveals that effective programs are culturally appropriate, use the client population's native language(s), incorporate the values and beliefs of the population served, and address social and cultural factors that affect the success of intervention and care programs. Finally, service provision also must overcome economic and transportation issues and attempt to redress the discrimination and alienation that keep individuals from seeking care. Only by overcoming numerous barriers that hamper the ability of individuals to make healthy decisions about their lives will the spread of HIV decline and the effects of the epidemic be reduced.

References for this article are available on the HIV/AIDS Bureau web site <<http://www.brsa.gov/bab>>.

Male Adult/Adolescent AIDS Cases

By Exposure Category and Race/Ethnicity, 1997



- MSM
- IDU
- MSM/IDU
- Heterosexual Contact
- Risk Not Reported
- Other

AFRICAN AMERICAN AND LATINO MEN WHO HAVE SEX WITH MEN

Notwithstanding changes in the AIDS epidemic, the highest number of new AIDS cases reported each year is still among men who have sex with men (MSM); in 1997, 43 percent of those cases were among “Blacks” and “Hispanics.”

Recent evidence suggests that the number of new HIV infections—estimated at approximately 40,000 per year among the total U.S. population—is increasing among African American and Hispanic MSM; there also is evidence suggesting that some MSM may be becoming less risk-averse.^{1,2} Risky behavior is in many instances associated with substance abuse, particularly non-injected substance abuse. (See *HRSA Care ACTION*, “Substance Abuse and the HIV Epidemic,” April 1998.)

Primarily due to better medical treatment, the number of new AIDS cases is falling each year among the general population and among all segments of the population for which surveillance data are reported by the CDC. But the number of new AIDS cases reported annually among some MSM of color, particularly African American and Hispanic men, is not falling nearly as precipitously as among White MSM or some other segments of the population.

African American and Latino men account for an increasing portion of AIDS cases among MSM and MSM/IDU

African Americans

Twenty-seven percent of AIDS cases reported among MSM in 1997 were among Blacks, up from 23 percent in 1995.³

Thirty-eight percent of AIDS cases reported among MSM/IDU in 1997 were among Blacks, up from 33 percent in 1995.

Latinos

Fifteen percent of AIDS cases reported among MSM in 1997 were among Hispanics, up from 14 percent in 1995.

Fifteen and one-half percent of AIDS cases reported among MSM/IDU in 1997 were among Hispanics, up from 14.5 percent in 1995.

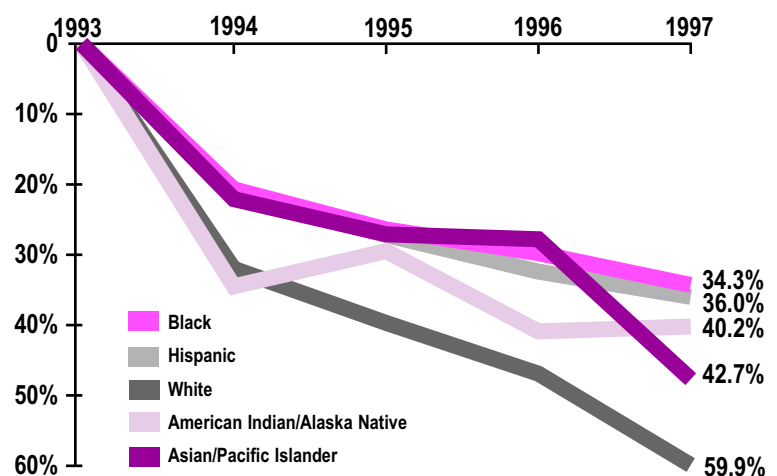
There is evidence that AIDS cases attributable to MSM and MSM/IDU are underreported, particularly among minorities; approximately 25 percent of AIDS cases reported in 1997 among minority men—compared to 11 percent among White men—have been classified in the CDC exposure category “risk not reported or identified.”

HIV prevention initiatives have not reached a large number of MSM of color. Moreover, research and evaluation clearly indicate that African American and Latino men in particular enter care later in disease stage than do White men; they are much less likely than their White counterparts to be seeing a physician regularly or to be taking antiretroviral therapy.

Implications of provider-reported characteristics and circumstances for service provision

Ryan White CARE Act grantees and providers interviewed for this article cautioned against generalizations about minorities and MSM of color. Race is an important factor in America, but it is just one of many components that defines culture. Economic status, education, religion, relationship with family, social

Decrease in New AIDS Cases Among Men By Race, 1993-1997



Source, CDC, HIV/AIDS Surveillance Reports, 1993-1997

support, employment, geographic location, and sexual orientation are some of the additional variables. Each of these must be considered when designing prevention messages and services for particular segments of the population. If they are ignored, prevention and treatment are less likely to be effective.

Intervention models can be strengthened by reflecting these characteristics and distinct needs identified by providers.

- Same sex behavior among MSM of color may be less likely to indicate homosexual or bisexual self-identity than same sex behavior among White men. Spectrum, a Ryan White CARE Act provider in Los Angeles serving African American and Latino men, confirms that of the 75 percent of its HIV-positive male clients whose risk factor is MSM, 65 percent identify as heterosexual. Similarly, selected providers in Los Angeles, Chicago, and Washington, D.C. serving predominantly minority men also report a high number of clients who have sex with other men but who do not identify as gay or bisexual.

Implication: Messages and organizations publicly targeting “out” gay and bisexual men are not effective for men who identify as heterosexual who have sex with men.

- Minorities with HIV are more likely to be impoverished prior to infection than White MSM. Minorities in general are more likely to suffer economic distress, mental illness, addiction, violence, and a host of problems related to poverty, lack of opportunity, and racism.

Implication: These circumstances compromise the individual’s ability to prioritize HIV care, and have a negative impact on self-esteem; as self-esteem falls, the likelihood that the individual can adhere, keep appointments, overcome addiction, and successfully negotiate a host of associated problems also decreases. These problems must be addressed to improve the utilization of medical care.

Continued on Page 10

Spirituality is very important to these men; even when they identify as gay or bisexual, their identity is that of a black man first, and they are not going to leave black institutions. We have found that we must incorporate spiritual values into the services and programs we provide.

Eric Bing, M.D.
Executive Director
SPECTRUM
Los Angeles, CA

CARE Act programs have helped create better access to services for minorities, but the problem still exists for several reasons. For example, a lot of Latino and African American men who are HIV infected have been missed by traditional prevention and advocacy efforts because they have tended to target men who are empowered as "out" gay and bisexual men.

Ron Lewis
Administrator
Administration for HIV/AIDS
Washington, DC

If you are a man of color you are already dealing with the fact that there is less opportunity for education and employment. Drug use results as a coping mechanism; it's more socio-economic than racial perhaps, but race is still an important component.

Dale Green
Case Management Coordinator
Minority Outreach
Intervention Project
Chicago, IL

The main resources on the south side are public clinics. When someone thinks the clinic isn't doing a good job in terms of customer services, they won't go there unless they have to—unless they are symptomatic.

Rashad Burgess
Executive Director
Howard Brown Health Center
South Side Clinic
North Chicago, IL

Continued from Page 9 . . . MEN WHO HAVE SEX WITH MEN

- Reports from providers suggest that a larger proportion of minority MSM, particularly African American men, rely on religious institutions for social support and spiritual nurturing at higher rates than do White MSM. These men also desire that a spiritual component be incorporated into the services they receive.

Implication: Health care providers, community-based organizations, churches, and other religious organizations must collaborate to strengthen their HIV prevention interventions and offer programs that build self-esteem in those living with HIV disease. With improved self-esteem, the likelihood increases that gay and bisexual men will maintain safe behaviors and seek medical treatment.

- MSM of color are more likely to encounter a provider of care with whom they do not identify, and who does not identify with them. The history of racism in society continues to be a significant barrier. Moreover, circumstances and cultural norms of the provider and the client may be so completely different that communication and empathy are difficult.

Implication: Individuals do not feel comfortable when they perceive that they are not understood. They will avoid these situations, and the result often negatively affects their health and well being. Specific interventions to increase cultural competency often are warranted.

- Language continues to be a significant barrier to care for men of color, particularly Latino men. Some providers, like La Clinica del Pueblo in Washington, D.C., report that up to 95 percent of their Latino clients are not fluent in English; barriers to medical care as well as a whole series of social and support services are the result.

Implication: Language fluency for providers who serve linguistic minorities is essential. (A discussion of the needs of linguistic minorities will be featured in the next issue of *HRSA Care ACTION*.)

Programs that serve sub-populations must have as their foundation the defining characteristics of these groups. Institutions constructed and strategically positioned to meet the needs of other populations—populations whose needs may be much less complex than those of minority MSM—cannot adequately serve men of color unless they adapt to the specific circumstances and

Providers interviewed for this article also have indicated a set of approaches that are key to serving MSM of color, and African American and Latino men in

particular. These points are a synthesis of fundamental principles that should be considered

Two EMAs Respond to the Needs of Minorities

Chicago EMA

The Chicago EMA is providing capacity building services to organizations serving communities of color. Technical assistance is provided to agencies on topics ranging from management and budgeting to fundraising and board development. Short-term professional support is offered when a critical staff shortage exists or when training is needed; one goal of this capacity building component is to make these agencies competitive for funding.

In partnership with HRSA's Midwest AIDS Education and Training Center, the EMA is implementing a program to identify doctors located in communities of color and evaluate their capacity and capability to provide HIV services. Doctors then are recruited for a fellowship program or for coordinated linkages with more knowledgeable and capable providers. Simultaneously, the EMA is bringing CBOs to the table that are established in communities of color but that have not previously been involved in HIV prevention.

Finally, the grantee is leading the development of a continuum of care that assures that individuals released from detention receive quality care once they return to the community; in the Chicago area, the quality of care received in prison often is better than that which the individual encounters upon release.

Los Angeles EMA

The Los Angeles EMA provides capacity building to small community-based organizations serving minority populations—many of which are only beginning to provide HIV services—so that their role in the community is secure over time, using both CARE Act and public funds for L.A. County. The EMA also is collaborating with political and community leaders to develop a leadership council on HIV that can garner widespread support for HIV interventions across a broad spectrum of the population. The grantee is committed to a staff that reflects the diversity of the community in terms of culture and race so that the problems encountered by *all* individuals can be better understood and addressed. The EMA is reprioritizing evaluation, again using both CARE Act and non-CARE Act funds, to assure maximum outcome from investment. Similarly, the EMA is using mapping technology to assure that services are contracted in the neighborhoods where they are most needed. The grantee is specifically collaborating with churches because these institutions play a pivotal role in the lives of individuals of color. The grantee also is seeking to establish stronger linkages between counseling and testing and treatment.

when designing programs to serve African American and Latino men of color. These include:

1. Place the organization in the geographic area most accessible to the target population. Make transportation a non-issue.
2. Identify the target population using trends in available local HIV estimates. Do not rely on AIDS cases alone, because they provide an increasingly incomplete picture of the epidemic.
3. Do not identify the organization as "gay" or as HIV oriented, and co-locate both HIV and non-HIV related services when serving MSM for whom anonymity is a priority.
4. Ensure that the life circumstances of the target population are understood and respected by program staff, through employing peers and providing training.
5. Link prevention and early intervention services; that men of color come into treatment later than Whites indicates that outreach for prevention and case finding are needed.
6. Perform outreach in a wide array of locations, not just bars; include cruising parks, churches, and places where MSM of color who do not identify as gay or bisexual can be reached. Use trained outreach workers who are indigenous to the community.
7. Provide opportunities for socialization and support services for hard-to-reach men before discussing HIV. Without the development of trust between the provider and the client, the individual is less likely to heed a prevention message, be tested, or enter care.
8. Don't assume that cultural norms apply across segments of the MSM of color population.
9. Build managerial and technical capacity within the organization so that it is viable in the community over the long term.

Note

- AIDS among Asian and Pacific Islander, and American Indian and Alaska Native MSM will be discussed in the March issue of *HRSA Care ACTION*.

References for this article are available on the HIV/AIDS Bureau web site <<http://www.brsa.gov/bab>>.

National Survey of African Americans on HIV/AIDS

A September-October 1997 survey by the Kaiser Family Foundation, published in March 1998 as "National Survey of African Americans on HIV/AIDS," showed that more than one-half of those surveyed rated AIDS as the most urgent health problem facing the Nation today, well above cancer (36 percent), and heart disease (13 percent). The survey underscored that this sense of urgency was shared at all economic and educational levels of the African American community. The survey indicated that the African American community recognizes and is concerned about the increasing disparity of the epidemic's impact, viewing it as a national health priority. Other findings:

Sixty-six percent indicated that the government spends too little money on AIDS.

Sixty-two percent of African Americans, compared to 46 percent of a national sample of all Americans, want information on what to discuss with their children on AIDS prevention.

Free copies of the survey (#1372) may be obtained from the Kaiser Family Foundation's publication request line at 1-800-656-4533.

HRSA Care ACTION

is published by the Health Resources and Services Administration, Department of Health and Human Services. All information contained herein is in the public domain.

Please forward comments, letters and questions to:

HRSA Care ACTION
Office of Communications
HIV/AIDS Bureau, HRSA
5600 Fishers Lane, Room 7-46
Rockville, MD 20857
Phone: 301-443-6652
Fax: 301-443-0791
or by E-mail to: koneill@hrsa.gov