



**Communities At Risk:**  
**HIV/AIDS**  
**in Communities of Color**

**A Report of the New York State  
AIDS Advisory Council**

**Winter 2000/2001**

# NEW YORK STATE AIDS ADVISORY COUNCIL

Allan Rosenfield, M.D.

**Chairperson**

Dean, Mailman School of Public Health  
Columbia University

Megan McLaughlin, D.S.W.

**Vice Chairperson**

Executive Director/CEO  
Federation of Protestant Welfare Agencies

Hon. Thomas K. Duane

Member of the Senate

Hon. Roy M. Goodman

Member of the Senate

David A. Hansell, Esq.

NYC Department of Health

Lambert N. King, M.D., Ph.D.

Saint Vincent's Catholic Medical Centers

Keith Krasinski, M.D.

New York University Medical Center

Sr. M. Antonia Maguire, F.M.S.C.

Mt. St. Francis

William F. McCarthy

Edwin A. Mirand, Ph.D.

Roswell Park Cancer Institute

Mark S. Rapoport, M.D.

Jeffrey L. Reynolds

Long Island Association for AIDS Care, Inc.

Felix Velazquez

PROMESA, Inc.

William A. Viscovich, Esq.

Attorney at Law

Barbara Williams

Health Force

**Communities At Risk:**  
**HIV/AIDS**  
**in Communities of Color**

**A Report of the New York State  
AIDS Advisory Council**

**Winter 2000/2001**



# **Communities At Risk: HIV/AIDS in Communities of Color**

## **CONTENTS**

---

<b>Executive Summary</b>	<b>-i-</b>
<b>COMMUNITIES AT RISK</b>	
<b>Introduction</b>	<b>1</b>
<b>Race, Ethnicity, and Culture</b>	<b>4</b>
<b>Epidemiology</b>	<b>7</b>
<b>HIV/AIDS in People of Color</b>	<b>9</b>
<b>Risk Factors for HIV/AIDS in People of Color</b>	<b>14</b>
<b>Current HIV/AIDS Funding and Services</b>	<b>18</b>
<b>New York State Funding and Services</b>	<b>18</b>
<b>New York City Funding and Services</b>	<b>22</b>
<b>Strategies for Communities of Color</b>	<b>25</b>
<b>CDC Recommendations</b>	<b>25</b>
<b>New York State AIDS Advisory Council     Presentations and Deliberations</b>	<b>27</b>
<b>The Future of HIV/AIDS in Communities of Color</b>	<b>30</b>
<b>HIV/AIDS in Communities of Color Principles and Recommendations</b>	<b>31</b>
<b>List of Presentations to the New York State AIDS Advisory Council</b>	<b>43</b>
<b>Endnotes</b>	<b>45</b>

---

## **APPENDICES**

- I**     **Provider presentations on HIV/AIDS  
in communities of color**
- II**    **Direct services funding administered by the  
New York State Department of Health AIDS Institute**
- III**   **HIV/AIDS and communities of color websites**



# **Communities At Risk: HIV/AIDS in Communities of Color**

## **A Report of the New York State AIDS Advisory Council**

### **EXECUTIVE SUMMARY**

**I**n the United States, there have been more than 700,000 AIDS cases to date, nearly one in five of them in New York State. Since the earliest years of the epidemic, it has been apparent that HIV/AIDS disproportionately affects African Americans and Hispanics. These groups together constitute 25 percent of the U.S. population, but account for more than half of cumulative AIDS cases and nearly two-thirds of new AIDS cases reported in 1998. Among U.S. women, African Americans and Hispanics represent less than one-fourth of the total but account for 77 percent of cumulative AIDS cases. The numbers of cases in Asians/Pacific Islanders and Native Americans/Alaskan Natives, while small, show signs of increasing.

AIDS affects people of color even more disproportionately in New York State than in the U.S. as a whole. As of September 30, 1999, New York had recorded more than 136,000 cases of AIDS, 42 percent of them in African Americans and 31 percent in Hispanics, a total of nearly three-fourths of all cases. African Americans and Hispanics account for 90 percent of New York State AIDS cases in children under 13 and 92 percent of those in inmates. Although African Americans and Hispanics total about 32 percent of the current population of New York, the proportion of newly reported AIDS cases in these groups has increased over time from 57 percent in 1985 to 80 percent in 1997. Cases in Asians/Pacific Islanders and in Native Americans/Alaskan Natives remain under 1 percent in each group.

Here, as elsewhere in the world, HIV/AIDS rates are just one of many indicators of poor health stemming in some measure from social and economic inequities in communities of color. AIDS is part of a constellation of factors, such as high rates of injection drug use, poverty, and inadequate access to quality health

care, particularly preventive care, that together put people of color at greater risk for HIV infection. It is evident that public health efforts, despite being clearly well intentioned and in New York State well funded, have not yet designed adequate responses to prevent the spread of HIV/AIDS in communities of color, where HIV has reached significant proportions.

Dr. Megan McLaughlin, Vice-Chairperson of the New York State AIDS Advisory Council, initiated discussions about HIV/AIDS in communities of color within the Council in 1998 and provided persistent impetus for attention and action. Following initial presentations in late 1998, the Council chose to consider this critical issue in full session, including speakers and discussion at nearly every monthly meeting from May 1999 through January 2000. Community representatives, AIDS program directors, and New York City and State health officials were invited to provide information about HIV/AIDS service needs and funding. Based on these presentations, recommendations were drafted in September 1999 and were subsequently developed into formal principles and recommendations, approved unanimously by vote of the Council in January 2000.

### **Race, ethnicity, and culture**

A number of considerations inform the discussion of HIV/AIDS in communities of color. First, although the term "race" has no actual biological or anthropological meaning and the term "ethnic group" (that is, people of any race who share cultural bonds) is preferred, this report will adhere to standard epidemiological practice with categories of non-Hispanic White (W), African American (AA), Hispanic (H), Asian/Pacific Islander (A/PI), and Native American/Alaskan Native (NA/AN).

Second, histories of past treatment, traditions, and beliefs have a bearing on receptivity to health information and services and on perceptions of good faith in calls for collaborative partnerships.

Third, correlation should not be interpreted to mean causality. Just as being gay is not in itself a risk factor for HIV infection, neither is being African American or Hispanic. There is a fear that, for people already disadvantaged by racism, becoming identified with a stigmatizing disease may lead to even greater discrimination.



Fourth, the terms "culture" and "community" should also be used with caution. Every population may consist of many subpopulations and every community of many culturally diverse individuals, which is particularly true in New York City. All groups exhibit great variation in socioeconomic status, language skills, acculturation, and health status.

Finally, the health care setting is itself an environment that people of any background may find to be impenetrable or frightening. Although similarity of ethnic background between health provider and patient is often helpful, it is no guarantee of caring, effective health service. Providers and planners should seek to develop "cultural competence" in their programs and examine every aspect of the health care setting for qualities that encourage or discourage access.

### **Trends**

Both New York State and the U.S. as a whole are becoming more diverse. New York State has a higher proportion of people of color than the country in general, and this characteristic will become more pronounced as Hispanic and Asian populations continue to grow rapidly. By 2025, people of color and Hispanics (including white Hispanics) will constitute more than 52 percent of the population of New York State (from about 42 percent in 1998). Poverty has substantial impact on health and is a pervasive concern in many communities of color. New York State had 16.6 percent of people below the poverty line during the period from 1996 to 1998.

AIDS mortality in New York State decreased by more than 50 percent from 1995 to 1997, due in large part to advances in treatment for HIV and opportunistic infections, yet people of color with AIDS continue to have higher death rates than whites. Rates of new AIDS diagnosis have also declined, but remain disproportionately high among people of color. However, since rates of AIDS incidence and mortality reflect patterns of HIV transmission ten or more years in the past, they are inadequate measures of current HIV infection trends. When data on HIV incidence and prevalence are available from HIV surveillance studies beginning in New York in 2000, they will likely show even greater disparities between people of color and whites.

Injecting drug use (IDU) is a much greater factor in AIDS among people of color in New York State than nationally. Among African American and Hispanic adults and adolescents nationwide, injection drug use accounts for 36 percent of all cases, compared to 22 percent for whites. For African American and Hispanic men and women in New York, more than half of all cases are attributed to IDU.

While AIDS incidence among men who have sex with men (MSM) is decreasing overall, this risk still accounts for 60 percent of new infections in men each year in the U.S. and is a factor of dramatic and increasing concern in communities of color. U.S. AIDS cases in men of color who have sex with men jumped from 31 percent of total MSM cases in 1989 to 52 percent in 1998 (up 74 percent in blacks and 50 percent in Hispanics), surpassing the 48 percent among white men. It is suspected that there are significantly higher rates of HIV infection among MSM of color, especially African Americans, than among whites, and that MSM of color are being infected with HIV at younger ages.

Heterosexual sex is a significant route of HIV transmission for U.S. women, accounting for 40 percent of U.S. female adult/adolescent AIDS cases reported through June 1999. In New York women, by comparison, heterosexual sex accounts for 29 percent of AIDS cases in African Americans, 36 percent in Hispanics, 37 percent in Asians/Pacific Islanders, and 22 percent in Native Americans/Alaskan Natives. Many women are unaware of their partner's HIV status or risk behavior and lack the power and/or skills to negotiate protection. Young women of color are at particularly high risk.

Nearly 28,000 cumulative cases of AIDS in young people 13 to 24 were reported in the U.S. through June 1999. About 43 percent of these were in African Americans and 22 percent in Hispanics. It is estimated that at least half of all new HIV infections are among people under 25, most of whom are infected sexually. All people of color, but women and young people in particular, show rising new case rates.

### **New York's Response**

Since the start of the epidemic, the New York State Department of Health AIDS Institute has recognized that specifically designed HIV/AIDS service models are required to meet the needs of geographic areas, communities, racial and ethnic groups,

subpopulations within these groups, substance users, gay/bisexual men, women, young people, and other particular populations such as inmates, immigrants, the homeless, and the mentally ill. Regardless of a program's primary focus, there is no AIDS Institute program that does not in some way serve people of color.

For fiscal year 1999-2000, total AIDS Institute state and federal funding was just under \$340 million. Statewide, for more than 300 of 466 contracts, people of color represent 75 percent to 100 percent of the caseload. There has been increasing utilization of the AIDS Drug Assistance Program (ADAP) by people of color, and use of combination antiretroviral therapy has increased to 80 percent or better for all groups of enrollees in ADAP, which serves uninsured and underinsured people with HIV. In addition, the Medicaid program in New York spends over \$1.5 billion per year from state, federal, and local sources for treatment of persons with HIV/AIDS, a large proportion of whom are persons of color.

New York City spent \$125 million in city and federal funds in fiscal year 1999-2000 to provide HIV/AIDS treatment and prevention services and also paid its local share of Medicaid expenditures.

### **New York State AIDS Advisory Council Principles & Recommendations for Communities of Color**

Reducing rates of HIV/AIDS in communities of color is a matter of the greatest urgency. Preventing HIV and AIDS should be one of the highest public health priorities, accorded substantial funds and serious attention by legislators, health administrators, providers, and communities themselves.

Although increased funding, particularly for prevention, is essential, it is not all that is needed. Among the major tasks is the development of expanded partnerships with community leaders and organizations willing to take on the vital work of helping to design and implement new strategies for combating HIV/AIDS. A key public health principle is that effective public health interventions must be developed with and by affected communities. The Council is firmly committed to the idea that "top down" and "bottom up" efforts must meet and coalesce into focused, culturally appropriate campaigns that have credibility with affected populations and proceed with determination to change the course of epidemic. Researching and incorporating new health education approaches and methods to effect behavior change and

fostering consensus and momentum around these strategies are indispensable.

## **Principles**

The Council highlighted seven essential elements for improved HIV/AIDS prevention and services for communities of color:

- Recognition of the urgency of the problem
- Community engagement
- A strong emphasis on HIV prevention
- Specific attention to high risk populations
- Racial and cultural sensitivity
- A continuum of care
- A comprehensive approach, recognizing that HIV/AIDS is part of a larger constellation of health and social problems in the lives of many people of color.

## **Recommendations**

These essential elements became the principles on which the Council's recommendations are based. Each of the seven final recommendations are accompanied by a number of specific action steps to encourage rapid implementation. The overriding recommendations call for the following:

- A broad-based campaign to describe the extent and urgency of the problem
- Adoption of HIV prevention in communities of color as one of the highest public health priorities
- Increased funding and resources, particularly for HIV prevention
- Coordination of strategic planning through partnerships and coalitions
- A strategic plan that includes education and training about prevention methods, improved access to services, and extensive treatment education, all utilizing methods that are specific to communities of color and adaptable to individual circumstances and needs
- Specific initiatives to reach groups with a particularly high or growing risk of infection
- The fullest possible use of existing organizations, programs, and health systems.

The Council supports additional strategies that have been shown to be effective and that the Council believes can have significant impact on rates of HIV/AIDS in communities of color, such as harm reduction models for injection drug users, legalization of the purchase of needles and syringes, improved HIV/AIDS services for incarcerated and discharged inmates, intensified prevention education for women and adolescents, and equitable access to HIV therapies.

### **A Call to Action**

HIV/AIDS now constitutes one of the most urgent health problems faced by people of color. Although communities of color must work actively to meet this challenge, the problem cannot and should not be solved by people of color alone.

The New York State AIDS Advisory Council, in undertaking this report, is issuing a call to action. All communities must become involved in preventing HIV and caring for those with HIV/AIDS. All communities must commit themselves to expanding, refining, and implementing the recommendations set forth in this report.

New partnerships require a foundation of trust and a consensus for action. Finding strategies that will produce results quickly and efficiently requires openness to new ideas and research into the most current health education and behavior change strategies. These tasks are demanding but critical to reducing the intolerable burden of HIV/AIDS on communities of color.

*Special thanks to all those who assisted the Council in the development of this report. The Council appreciates the time and expertise of those professionals who spoke to the Council about their experiences providing services in New York communities. The Council also notes the significant work of the AIDS Institute Communities of Color Workgroup in reporting on key issues of concern to people and communities of color to effectively address the HIV epidemic in their midst. All of this expertise informed our understanding of the issues and the development of this report.*



# Communities At Risk

## Introduction

Twenty years after the first recognized cases, HIV/AIDS continues to be a highly virulent disease. Far from abating, it has become a central force in social, economic, and political affairs throughout the world. More than 33 million people are living with HIV worldwide. Another 16 million have died. There were 5.6 million new infections in 1999.<sup>1</sup>

In the United States, there have been more than 700,000 AIDS cases to date, nearly one in five of them in New York State.<sup>2</sup> Since the earliest years of the epidemic, it has been apparent that HIV/AIDS disproportionately affects African Americans and Hispanics.<sup>3</sup> More than half of all U.S. AIDS cases through June 1999 were reported in racial and ethnic minorities, more than a third in African Americans alone. African Americans and Hispanics together constitute 25 percent of the U.S. population, but represent nearly two-thirds of new AIDS cases reported in 1998.<sup>4</sup> The numbers of cases in Asians/Pacific Islanders and Native Americans/Alaskan Natives, while small, show signs of increasing.

In New York State these trends are even more pronounced. As of September 30, 1999, New York had recorded more than 136,000 cases of AIDS, 42 percent of them in African Americans and 31 percent in Hispanics, a total of nearly three-fourths of all cases.<sup>5</sup> Although African Americans and Hispanics together account for about 32 percent of the current population of New York State,<sup>6</sup> the proportion of newly reported AIDS cases that are in people of color has increased over time from 57 percent in 1985 to 80 percent in 1997. Cases in Asians/Pacific Islanders and Native Americans/Alaskan Natives constitute under 1 percent in each group.<sup>7</sup>

There is no evidence of increased biological susceptibility to HIV for any racial or ethnic group. The United Nations notes that "...poverty, poor health systems, and limited resources for prevention and care fuel the spread of the virus" in developing countries.<sup>8</sup> This is thought to be equally true in the U.S.

*"It is urgent that we act today to stop the scourge of this epidemic in our communities of color."*

Antonia C. Novello,  
M.D., M.P.H., Dr.P.H.  
New York State  
Commissioner of Health

In the United States, as elsewhere in the world, HIV/AIDS rates are just one of many indicators of poor health stemming in some measure from social and economic inequities in communities of color. People of color suffer higher rates of infant mortality, cancer, heart disease, diabetes, hypertension, and other disorders.<sup>9</sup> Women are less likely to receive early prenatal care; children are less likely to receive immunizations; more people are without health insurance; there are fewer health care providers and more avoidable hospitalizations.<sup>10</sup> Even when hospitalized, people of color receive less intensive care.<sup>11</sup> It has been noted that life expectancy for African American men in some urban areas in the United States resembles life expectancy in some third-world nations.<sup>12</sup> A similar observation was noted at the 1999 National Conference on African Americans and AIDS.<sup>13</sup>

*HIV/AIDS really brought candid discussion around sexuality to the table...It is now bringing class and racism to the table.*

Eric Goosby, M.D.  
Director, Office of  
HIV/AIDS Policy,  
Department of Health and  
Human Services

At the start of the year 2000, it is evident that public health efforts, despite being clearly well intentioned and in New York State relatively well funded, have not yet designed adequate responses to the spread of HIV/AIDS in communities of color. At the same conference, Eric Goosby, M.D., Director of the Office of HIV/AIDS Policy at the Department of Health and Human Services, noted "HIV and AIDS really brought candid discussion around sexuality to the table....It is now bringing class and racism to the table."<sup>14</sup> As difficult as it is to directly discuss these issues, it is impossible not to if the spread of AIDS is to be stopped.

HIV/AIDS has been called a crisis for twenty years, and indeed it has become a larger crisis each and every year. On October 28, 1998, the federal government announced a \$156 million initiative for prevention and treatment of HIV/AIDS in minority communities, the result of an intense effort, in which New York communities of color were active, to bring this issue to greater national attention.<sup>15</sup>

It will not be sufficient to simply do more of the same. It will not be sufficient to just expand existing programs or change the color of the program staff. When HIV/AIDS was thought to be a disease primarily affecting gay white men, it demanded new ways of thinking about health education, new types of programs and services, new ways to integrate them, and new partnerships for prevention and treatment. HIV has reached significant proportions in communities of color. It again demands vigorous, creative energy and ideas to combat continually rising infection rates.



## The New York State AIDS Advisory Council Response

In many of its reports, the New York State AIDS Advisory Council has highlighted the impact of HIV/AIDS on people of color. However, in 1998 Dr. Megan McLaughlin, Vice-Chairperson of the Council, initiated discussions specifically about HIV/AIDS in communities of color within the Council and began to provide consistent impetus for concerted attention. Rather than appoint a subcommittee, the Council elected to consider this critical issue in full session and included discussion at nearly every meeting from May 1999 through January 2000. The Council requested presentations from community representatives, AIDS program directors, and New York City and State health officials about HIV/AIDS services, needs, and funding. Materials from these presentations are summarized in and appended to this document.

To promote the search for new prevention and treatment strategies and to galvanize and support the efforts of agencies, legislators, community leaders, policy makers, and others, the Council gathered and formulated ideas for improved services and policies. Draft recommendations were first considered in September 1999 and were subsequently developed into the formal principles and recommendations, approved unanimously by the Council in January 2000, that conclude this report.

The Council considers it essential to continue to monitor this issue and encourage action by all who can help to reduce the rate of new HIV infections and ensure access to prevention and treatment services. The Council recognizes that initiatives to reduce HIV/AIDS in communities of color cannot wait for large scale efforts to change social and economic structures, but neither can they ignore the context in which HIV flourishes or fail to address the need to rethink prevention and health care strategies and entire systems of care in racially and ethnically diverse neighborhoods. It is hoped that this report will prompt both "top down" and "bottom up" pressure to enable prevention and health care programs to meet the needs in poorly served communities.

*What will the responses be? There is a great need for integrated systems of prevention and treatment for poor and underserved populations in general. People who test positive must be linked to care. People who test negative must have ongoing preventive services.*

Leo Rennie  
New York State HIV  
Prevention Planning Group

## Race, Ethnicity, and Culture

It is important to note at the outset that the term "race" is biologically and anthropologically meaningless. Race cannot be determined by genetic information. There is more genetic variation within racial groups than among them.

Although race is often used to refer to cultural heritage, geography, or any number of other variables, all races are culturally heterogeneous. A National Institutes of Health cancer research assessment committee recommended using the term "ethnic group" instead of race.<sup>16</sup> Ethnic terms, such as "Hispanic," apply to people of any race who share cultural bonds.

However, both racial and ethnic categories have traditionally been used in epidemiological research and continue to be useful barometers for monitoring AIDS cases and HIV infection rates. For purposes of this report, in keeping with current epidemiological practice, racial and ethnic groups will be identified as: African American (AA), Hispanic (all races unless specified) (H), Asian/Pacific Islander (A/PI), and Native American/Alaskan Native (NA/AN).

With regard to HIV/AIDS, it is also useful to keep in mind that the development of trusting provider-patient relationships, essential for effective health care, is a difficult and delicate process that touches on many aspects of experience, tradition, and belief. Histories that recall systematic racial and ethnic bias and many forms of overt injustice and brutality necessarily have a bearing on receptivity to health information and services and on perceptions of good faith in calls for collaborative partnerships.<sup>17</sup>

There is also a concern in undertaking education about the burden of high HIV/AIDS rates in communities of color that high disease rates not become an additional type of stigma, that is, that correlation not be interpreted to mean causality. Just as being gay is not in itself a risk factor for HIV infection, neither is being African American or Hispanic. Among many reasons for the historical difficulty of acknowledging the rapid spread of HIV among people of color is the fear that, for people already disadvantaged by racism, becoming identified with a stigmatizing disease will lead to even greater discrimination.

*It's not clear how words like "culture," "race," or "ethnicity" relate to research, practice, and intervention. Race and ethnicity must be recognized, but in context with other issues such as history and economics.*

Darrell Wheeler, Ph.D.  
Columbia University

The terms "culture" and "community" should also be used with caution. Every population may consist of many subpopulations and every community of many culturally diverse individuals. African Americans have varied geographic origins and ethnic backgrounds with roots from Haiti to Madagascar. The U.S. is home to the world's fifth largest population of Hispanics, consisting largely of people who are ethnically Mexican (63 percent), followed by Central and South American (14 percent), Puerto Rican (11 percent), Cuban (5 percent), and Spanish/Mexican/Native American (7 percent), with different mixes in different areas.<sup>18</sup> In New York, Hispanics are primarily from Puerto Rico, the Dominican Republic, and Central and South America. In the U.S., there are different Asian groups, and Pacific Islander groups, that together speak more than 100 languages, although six groups account for 95 percent of the Asian/Pacific Islander population in the U.S: Chinese, Filipino, Japanese, Asian Indian, Korean, and Vietnamese. There are 221 distinct Native American languages and dozens of tribes.<sup>19</sup> Men, women, adolescents, and children also have particular interests and needs within each ethnic category.

*Just as being gay is not in itself a risk factor for HIV infection, neither is being African American or Hispanic.*

All groups exhibit great variation in socioeconomic status, language skills, beliefs, acculturation level, and health. Stereotypes are as damaging to public health goals as to individuals. For example, the assumption that many communities of color are characterized by illegal drugs and poverty ignores strong community networks and religious organizations that can play vital roles in HIV prevention and treatment. The "model immigrant" label often applied to Asians obscures the fact that many work in low wage jobs, are uneducated, and have no health insurance.<sup>20</sup>

Finally, the health care setting is itself a culture that people of any background may find to be impenetrable, frightening, or even hostile. Although similarity of ethnic background between health provider and patient is often helpful, it is no guarantee of caring, effective health service.<sup>21</sup> In addition to the specific development of cultural competence in providers, every aspect of the health care setting and every policy deserves examination for qualities that encourage or discourage access and contribute to or detract from an environment where trusting therapeutic relationships can be formed and maintained.

### **Cultural competence**

The President's Initiative on Race defines cultural competence within the public health system as care that "is given with an understanding of and respect for the patient's health-related beliefs and cultural values, takes into account disease prevalence and treatment outcomes specific to different populations, and [engages]

the active participation of community members and consumers....By understanding, valuing, and incorporating cultural differences...and examining one's own health-related values and beliefs, health providers deliver more effective and cost-efficient care."<sup>22</sup>

This is not an easy task. Language, for example, is not a matter of simple translation, as though even translation is simple. Language has to do with many kinds of meaning: assumptions, perceptions, nuances of style and manners, cultural traditions and prohibitions. Even in English, sexual practices and the names for them can vary widely. Bureaucratic language can intimidate and disempower patients.

Cultural explanations for disease and traditional health practices may conflict with scientific ones. In some Hispanic cultures, for example, illness is thought to result from witchcraft, bad air, or imbalances of hot and cold in food or climate. Many Native Americans fear that illness results from loss of the soul, supernatural power, contact with the dead, violation of taboos, or natural origins. Asians may share many of these beliefs. Individuals and groups may be convinced they are immune to HIV infection, believe they have no power to counter destiny, or have cultural prohibitions about discussing sex.<sup>23</sup>

Expectations about contact with the health care system also vary considerably. Many people trust information from family, friends, and members of their community far more than that from "outsider" health professionals. Some rely entirely on information from the media. Confidentiality of information is a great concern.

Attitudes toward condom use, homosexuality, and gender roles, as well as the stigma associated with drug use, all affect receptivity to and provision of HIV care.<sup>24</sup>

Skills to negotiate these issues are just now being developed and integrated into program planning.

*Heterosexual contact, work in cities, and other exposure to non-native people have increased the risk of HIV for Native Americans. They must be involved in meetings, groups, and policy discussions.*

Cissy Elm  
Onondaga Nation

*Asian cultures avoid discussing sexual behavior, illness and death. Soon the highest number of AIDS cases will be in Asia. Given projected immigration patterns, prevention will become even more essential, along with solutions to cultural, linguistic, economic, legal, and institutional barriers to health care.*

David Chen  
Chinese American Planning Council

# Epidemiology

There is often a tension in discussions about HIV between those who focus on personal responsibility and those who stress social and cultural factors that encourage high risk behavior or in some cases make it unavoidable. Personal responsibility and social conditions specifically intersect, for example, for the wives and partners of men who refuse to use condoms; for children and adults who negotiate sex for drugs, shelter, or money; for those whose judgement is incapacitated by drugs; or for immigrants who fear deportation on contact with health and social service providers. Most people have basic information about HIV transmission and how to prevent it, but individual behavior takes place in a socioeconomic context. Race and ethnicity are part of this dynamic equation.

According to a recent study "The analyses indicate that variables such as access and receptivity to HIV prevention and treatment efforts, race/ethnicity, sexual behaviors, sexually transmitted diseases, socioeconomic status, and substance abuse interact in a complex fashion to influence HIV transmission and progression to AIDS in affected communities." The federal Centers for Disease Control and Prevention agree. "The data suggest that three interrelated issues play a role — the continued health disparities between economic classes, the challenges related to controlling substance abuse, and the intersection of substance abuse with the epidemic of HIV and other sexually transmitted diseases (STDs)."<sup>25</sup>

## Changing demographics

Both New York State and the U.S. as a whole are becoming more diverse. Although people of color are currently estimated to constitute under 30 percent of the U.S. population of nearly 275 million,<sup>26</sup> they are expected to reach 40 percent of 350 million Americans in 2030.<sup>27</sup> African Americans will increase from 12 percent to 13 percent, Hispanics from 11.6 percent to 19.4 percent, and Asians, the fastest growing group in all regions of the country, from 3.8 to 6.7 percent.<sup>28</sup>

New York, the third most populous state, had an estimated population of 18.2 million people as of July 1999. In the past decade, although the population has increased only 1 percent, the demographics have changed substantially. From 1990 through 1998, it is estimated that the African American population increased 5 percent, Hispanics 19 percent, Asians/Pacific Islanders 40 percent, and Native Americans/Alaskan Natives 14 percent, while whites, including Hispanic whites, decreased 2 percent.<sup>29</sup>

These trends are expected to persist. New York State has a higher proportion of people of color than the country in general, and this characteristic will become more pronounced as Hispanic and Asian populations continue to grow rapidly.<sup>30</sup> By 2025, people of color and Hispanics (including white Hispanics) will constitute more than 52 percent of the population of New York State (from under 42 percent in 1998). This estimate suggests that the proportion of Hispanics will increase by about 50 percent (to nearly 22 percent of the population) and that of Asians will more than double (to nearly 10 percent).<sup>31</sup>

New York State is expected to gain 3.9 million people through international migration between 1995 and 2025, giving it the second largest net international migration gain. It will move from third to fourth most populous state with a projected population of 19.8 million.<sup>32</sup>

## Poverty

Poverty is a persistent and pervasive concern with substantial impact on health. Poor health is a function not only of absolute economic status, but also of the degree of economic disparity within a society.<sup>33</sup>

In 1998, the official poverty line was \$16,660 for a family of four. Despite general economic prosperity throughout the nation and improvements since the high poverty figures of 1993, the rate of poverty has remained fairly constant (12.7 percent in 1998) and the number of people below the poverty line has increased somewhat (from 30 to 34.5 million) during the twenty years of the HIV/AIDS epidemic.<sup>34</sup>

Although there have been some gains by people of color, substantial differences in economic status remain among racial and ethnic groups. In 1997, more than half of those below the poverty line were people of color and Hispanic origin.<sup>35</sup> In 1997, the median

*Although there have been some gains by people of color, substantial differences in economic status remain among racial and ethnic groups.*

household income for Asian/Pacific Islanders was \$45,249; for whites (including Hispanic whites) \$38,972; for people of Hispanic origin regardless of race \$26,628; and for African Americans \$25,050.<sup>36</sup> These figures should not obscure the often dramatic variation in economic status within groups. Further, foreign-born residents and newly arrived immigrants earn far less on average than established residents.

## HIV/AIDS IN PEOPLE OF COLOR

In recent years, there has been a decrease in the overall rate of new AIDS cases as well as a decrease in AIDS-related deaths. These trends are thought to be the result of powerful new treatments for HIV infection. However, the Centers for Disease Control and Prevention (CDC) notes, "...the slowing rate of decline may indicate that much of the benefit of new therapies has been realized...In addition, the duration of the effect of treatment may be limited for some persons."<sup>37</sup> There has not been a comparable decline in HIV infection rates.<sup>38</sup> Further, these gains have not benefitted all groups equally.

*In five years, cumulative AIDS cases in people of color in the U.S. increased from 51 percent to 57 percent.*

### Cumulative Totals

Comparison of the cumulative total of more than 700,000 AIDS cases in adults, adolescents, and children reported in the U.S. through June 1999 with the 400,000 cases as of June 1994 shows a 5 percent decrease in the proportion of white-non-Hispanics, an increase of nearly 5 percent for African Americans, and small increases for Hispanics and Native Americans. The proportion of cumulative AIDS cases among people of color overall increased from 51 percent to more than 57 percent.<sup>39</sup> African Americans and Hispanics, together less than one-fourth of U.S. women, account for 77 percent of cumulative AIDS cases in women.<sup>40</sup>

*African Americans and Hispanics, together less than one-fourth of U.S. women, account for 77 percent of cumulative AIDS cases in women and 75 percent in young people.*

Nearly 28,000 cumulative cases of AIDS in young people thirteen to twenty-four were reported in the U.S. through June 1999; African Americans total 43 percent and Hispanics total 22 percent.<sup>41</sup>

As of September 30, 1999, New York State had recorded nearly 137,000 cases of AIDS, 80.6 percent of them in New York City, 14.5 percent in upstate regions, and 4.9 percent in state prison inmates. This total includes more than 2,100 cases in children under 13.<sup>42</sup>

AIDS affects people of color even more disproportionately in New York State than in the U.S. as a whole, with 73 percent of New York State AIDS cases in African Americans and Hispanics, compared to 55 percent in the entire country. Of 134,602 adult/adolescent AIDS cases (including inmates), 56,042 are African American (41.6%), 40,185 are Hispanic (29.8%), 37,299 are White (27.7%), 790 are Asian/PI (.6%), and 66 are Native American (>1%).

*AIDS affects people of color even more disproportionately in New York than in the U.S. population as a whole. About 73 percent of cumulative AIDS cases in New York are among persons of color.*

**Table 1. Cumulative AIDS cases in adults and adolescents by race/ethnicity. U.S. and New York State (Data as of 6/99).**

Race/Ethnicity	U.S. <sup>43</sup>	N.Y. <sup>44</sup>
White, non-Hisp	44%	28%
African American	37%	42%
Hispanic	18%	30%
Asian/PI	.7%	.6%
Native Amer/AN	.3%	.05%

African Americans and Hispanics account for 90 percent of New York State AIDS cases in children under 13 and 92 percent of those in inmates.<sup>45</sup>

### Newly Reported Cases

Looking at newly reported cases of HIV and AIDS, these trends are more pronounced.

All people of color, but women and young people in particular, show increased new case rates. Women accounted for 23 percent (more than triple the 1985 proportion<sup>46</sup>) of the nearly 47,000 new adult and adolescent AIDS cases reported in the U.S. in the one year period ending June 1999. In men, African Americans and Hispanics represented over 61 percent of new AIDS cases and more than 58 percent of new HIV cases. In women, these groups accounted for over 80 percent of new AIDS cases and 76 percent of new HIV cases.<sup>47</sup>

*In the year ending June 1999, 67 percent of new adult AIDS cases and 63 percent of new adult HIV infections in the U.S. were in people of color.*

Overall, 66 percent of new adult AIDS cases and 62 percent of new adult HIV infections were in African Americans and Hispanics.<sup>48</sup> Asian/Pacific Islanders accounted for .7 percent of new adult AIDS cases and .4 percent of new adult HIV infections, and Native Americans/Alaskan Natives represented .4 percent and .6 percent, respectively.



Although **African Americans** constitute just over 12 percent of the U.S. population, 46 percent of AIDS cases reported from July 1998 to June 1999 were in African Americans, more than any other racial or ethnic group. About 62 percent of new cases in women and 63 percent of those in children were in African Americans. The overall 1998 AIDS case rate in African Americans was twice that in Hispanics and eight times that in whites.

It is estimated that about one in fifty African American men and one in one hundred sixty African American women is infected with HIV. HIV is the leading cause of death for African American men and women 25 to 44 (fifth for Americans overall).<sup>49</sup>

In the 13 to 24 age group, about 43 percent of new AIDS cases and nearly 49 percent of new HIV cases were in females in the one year period ending June 1999. Data from the 33 areas with confidential HIV reporting through June 1999 indicate that 56 percent of new HIV infections in this age group were in African American youth.<sup>50</sup>

It is estimated that at least half of all new HIV infections are among people under 25, most of whom are infected sexually. About two-thirds of the estimated 12 million cases of STD (other than HIV) diagnosed annually in the U.S. are in people under 25.<sup>51</sup> In a CDC study of young adults, crack smokers were three times more likely to be HIV-positive than non-crack smokers.<sup>52</sup>

Of 322 new pediatric AIDS cases (under age 13) and 262 new pediatric HIV infections in this period, 88 percent and 82 percent, respectively, were in African American or Hispanic children. A/PI accounted for .3 percent of new pediatric AIDS and .8 percent of new pediatric HIV, and NA/AN represented .3 percent and 0 percent.<sup>53</sup>

**Hispanics** constitute just under 12 percent of the U.S. population, but accounted for 20 percent of new AIDS cases from July 1998 to June 1999. This rate was four times that in whites. Seroprevalence data is not available from many states with large Hispanic populations, but there are indications of rapidly increasing infection rates.<sup>54</sup>

*It is estimated that at least half of all new HIV infections are among people under 25. Young women of color are at particularly high risk.*

*Adolescents on the street often exchange sex for food and shelter for themselves or their families. Information about risk reduction is not sufficient. Providers must change their antiquated views and questions to reflect the reality of adolescent sexuality.*

Verna Eggelston  
Hetrick Martin Institute

In New York State, the proportion of newly reported AIDS cases in African Americans and Hispanics increased from 57 percent in 1985 to 80 percent in 1997. In that period the percent of African American AIDS cases increased from 33 percent to 46 percent, Hispanic cases increased from 24 percent to 34 percent, white cases decreased from 42 percent to 19 percent and Asian/Pacific Islander and Native American/Alaskan Native cases remained under 1 percent. In AIDS cases diagnosed between 1994 and 1997, people of color accounted for 94 percent of pediatric cases, 89 percent of adolescent cases, and 73 percent of cases in people over 55.<sup>55</sup>

*In New York State, the proportion of newly reported AIDS cases in people of color increased from 57 percent in 1985 to 80 percent in 1997.*

Data on HIV infection rates (seroprevalence) in New York State are collected from a number of sources:<sup>56</sup>

- While women of color represented less than 50 percent of those giving birth in New York State from February through December 1997, they accounted for over 90 percent of HIV positive test results (of 904 positive tests, 62% were in African American women, 28% in Hispanics, and .7% in Asian/Pacific Islanders). In this period, most African American and Hispanic women had evidence of HIV testing during their current pregnancy, compared to just over one-third of white women.
- Rates in military recruits and Job Corps entrants tested between 1992 and 1997, while low, were two-to-fourteen times higher in people of color than in whites.
- Blinded HIV tests in drug treatment facilities (methadone maintenance, detoxification, and drug-free programs) from 1992 to 1997 revealed HIV rates two-to-five times higher in people of color than in whites. Among African Americans in these settings, the rates were 7 percent to 14 percent, among Hispanics 4 percent to 22 percent, and among whites 1 percent to 13 percent.
- HIV rates among incoming inmates in New York State correctional facilities, determined in blinded testing from 1992 to 1997, range from 19 percent in Hispanics to 13 percent in African Americans, and 8 percent in whites. In New York City correctional facilities, blinded studies on inmates at intake in 1996 found rates of 8 percent in Hispanics, 9 percent in whites, and 12 percent in African Americans.

- In state-operated anonymous HIV counseling and testing sites, HIV rates are generally low, but higher for persons of color than for whites. In 1997, these rates were 4.2 percent in African Americans, 3.2 percent in Hispanics, 2.4 percent in Native Americans/Alaskan Natives, 1.9 percent in Asian/Pacific Islanders, and .6 percent in whites.

**Table 2. Cumulative and recently reported AIDS cases by age group and race/ethnicity. New York State. (Data as of 9/99).**

Race/ Ethnicity	1998 State Pop <sup>57</sup>	Cumulative New York State AIDS Cases			AIDS Reported in 1997
		AIDS (all ages)	Adult/Adol AIDS <sup>58</sup>	Pediatric AIDS <sup>59</sup>	
White non-Hisp	65.4 %	27.5%	27.7%	9.5%	19%
African American	17.7 %	42.2%	41.6%	56.2%	46%
Hispanic	14.4 %	30.7%	29.8%	33.5%	34%
Asian/PI	5.5%	.6%	.6%	.4%	<1%
Native Amer/NA	4.2%	.05%	.04%	.1%	<1%

### Death Rates and PLWA

National AIDS death rates fell 42 percent from 1996 to 1997 and an additional 20 percent from 1997 to 1998.<sup>60</sup>

In 1993, among people living with AIDS (PLWA), whites far outnumbered other groups. It was estimated that there were three-fourths as many African Americans as whites living with AIDS, and less than half as many Hispanics. By 1998, more African Americans were living with AIDS than any other group. The estimate for Hispanics had increased to half the figure for whites.<sup>61</sup>

AIDS mortality in New York State decreased by more than 50 percent from 1995 to 1997, yet people of color continue to have the highest death rates. The decline was from 41 percent to 19 percent for African Americans, 38 percent to 15 percent for Hispanics, and 34 percent to 14 percent for whites.<sup>62</sup>

Of the 136,748 cumulative AIDS cases reported in New York State as of September 30, 1999, it is presumed that 52,501 adults, 779 children, and 3,894 prison inmates are alive.<sup>63</sup> This does not include people living with HIV or those with unreported AIDS. Rates of AIDS incidence and mortality are inadequate measures of current HIV infection trends since they reflect patterns of HIV transmission ten or more years in the past. When data on HIV incidence and prevalence are available from surveillance studies beginning in New York State in 2000, they will likely show even greater disparities between people of color and whites.

*AIDS mortality in New York State decreased by more than 50 percent from 1995 to 1997, yet people of color continue to have the highest death rates. HIV data, when available, will more clearly show this trend.*

## **RISK FACTORS FOR HIV/AIDS IN PEOPLE OF COLOR**

Since the start of the HIV/AIDS epidemic, injection drug use (IDU) has been responsible, directly or indirectly, for more than one-third of U.S. AIDS cases (59% of all cases among women and 31% among men). Among African American and Hispanic adults and adolescents this risk factor accounts for 36 percent of all AIDS cases, compared to 22 percent for whites. Sharing of contaminated syringes, sex with an injection drug user, and infection of infants born to women who contracted HIV through IDU or sex with an IDU partner are the principal ways in which drug use contributes dramatically to the spread of HIV. There are about 1 million active ID users in the U.S.<sup>64</sup>

In addition to the danger of HIV infection from needle sharing, non-injection drugs, such as “crack” cocaine, contribute substantially to the HIV epidemic when sex is exchanged for drugs or money and when drug use increases the likelihood of unprotected sex. Additional cases of AIDS are attributed to IDU in combination with other factors. (IDU figures in this report refer only to cases in which IDU is the sole risk factor.)

While AIDS incidence among men who have sex with men (MSM) is decreasing overall, it is estimated that this risk still accounts for 40 percent of all new HIV infections each year in the U.S. and 60 percent of new infections in men. Men having sex with men is a dramatic and increasing factor in communities of color. AIDS cases in MSM of color jumped from 31 percent in 1989 to 52 percent in 1998 (up 74% in blacks and 50% in Hispanics), surpassing the 48 percent among white men.

*U.S. AIDS cases in men of color having sex with men jumped from 31 percent in 1989 to 52 percent in 1998 (up 74% in blacks and 50% in Hispanics), surpassing the 48 percent among white men.*

A number of studies have shown marked increases in STDs among gay and bisexual men in recent years and significantly higher rates of HIV infection among men of color, especially African Americans (14% in one study), than among whites. MSM of color are

also being infected with HIV at younger ages.<sup>65</sup> There are, however, indications that HIV education programs have had impact among men who have sex with men. In a recent New York City survey, men stated they had fewer partners and used condoms more often, particularly with partners of unknown HIV status.<sup>66</sup>

Risk factors vary with country of birth. Among men born in Puerto Rico, risk factors are IDU 46 percent, heterosexual sex 25 percent, and sex with men 14 percent. For men born in Mexico, these figures are MSM 48 percent, heterosexual contact 11 percent and IDU 8 percent.<sup>67</sup>

Heterosexual sex is a significant route of HIV transmission for U.S. women, accounting for 40 percent of female adult/adolescent AIDS cases reported through June 1999.<sup>68</sup> Women are at risk for HIV infection from sexual partners who use injection drugs, are bisexual, or are already HIV-infected. Women often do not have knowledge about their partner's HIV status or risk behavior or the skills to insist on protection, especially if they exchange sex for drugs, money, or shelter. Since maternal HIV infection presents a significant risk of transmission to newborns, women are strongly urged to learn their HIV status before or during pregnancy.

### **Risk factors in New York State**

Of 134,602 cumulative adult/adolescent AIDS cases in New York State through September 1999, 78 percent are male. Risk factors for men are 42 percent injection drug use and 39 percent sex with men. For women, they are more than half IDU and one-third heterosexual contact.

Injecting drug use is a much greater factor in AIDS among people of color in New York State than nationally. For African American and Hispanic men in New York State, more than half of cases are attributed to IDU (higher than the one third in national statistics) and about 26 percent to MSM (lower than the 38% for African American men and 43% for Hispanic men nationally), whereas for white men in New York the figures are 67 percent MSM and 21 percent IDU.

For African American and Hispanic women in New York State, more than half of AIDS cases are also due to IDU (higher than the 44% for African American women and 41% for Hispanic women nationally). For New York State African American women, heterosexual sex accounts for 29 percent (compared to 37% nationally), and for Hispanic women 36 percent (compared to 47% nationally).

*Risk factors vary with country of birth. Among men born in Puerto Rico, IDU accounts for many more cases (46%) than heterosexual sex (25%), or sex with men (14%). For men born in Mexico, the major risk factor is MSM (48%), compared to heterosexual contact (11%) and IDU (8%).*

*For African American and Hispanic men in New York State, more than half of cases are attributed to IDU and about 26 percent to MSM, whereas for white men the figures are 67 percent MSM and 21 percent IDU.*

Of the AIDS cases in New York State Asians/Pacific Islanders and Native Americans, only a small percent are due to IDU, 9 percent in A/PI men and 14 percent in NA/AN men (compared to 5% and 14% nationally). Sex with men is 57 percent for A/PI men in New York (73% in the U.S.) and 37 percent for NA/AN men (57% in the U.S.) IDU accounts for 14 percent of cases among A/PI women and 55 percent among NA/AN women (versus 17% and 46% nationally), and heterosexual contact for 37 percent among A/PI women and 22 percent among NA/AN women (versus 48% and 46% nationally). However, numbers of A/PI and NA/AN AIDS cases in New York are small, so that risk estimates should be used with caution.<sup>69</sup>

*For African American and Hispanic women in New York, more than half of AIDS cases are also due to IDU (higher than the 44 percent for African American women and 41 percent for Hispanic women nationally).*

**Table 3. Cumulative New York State AIDS cases by risk factor and race/ethnicity.**

Race/ Ethnicity/ Gender		Risk Factors <sup>70</sup>		
		MSM	IDU	Heterosexual contact
White, non-Hisp	M	67%	21%	
	F		54%	32%
African American	M	26%	50%	
	F		51%	29%
Hispanic	M	26%	54%	
	F		52%	36%
Asian/PI	M	57%	9%	
	F		14%	37%
Native Amer/AN	M	37%	14%	
	F		55%	22%

Additional cases (not reflected in the chart above) are attributed to people with combined MSM/IDU risk factors, hemophiliacs, and early transfusion-related infections. Risk factors cannot be determined for a large number of people with AIDS in all ethnic groups.

## New York City

Through September 30, 1999, there were more than 110,000 cumulative cases of AIDS in New York City, more than the next four largest cities combined (Los Angeles, San Francisco, Miami and Washington). Patterns in New York City reflect those in New York State with 42 percent of New York City AIDS cases in African Americans, 32 percent in Hispanics, and 25 percent in whites.<sup>71</sup> Only 19 percent of new AIDS cases are among whites. Among women, 70 percent of cases are in people of color, with an increasing proportion of African Americans. Cases among men of color have increased from just over 50 percent in 1985 to more than 90 percent in 1998. The vast majority of men with AIDS under 30 who have sex with men are African American or Hispanic.

Although one-in-three people in New York City is foreign-born, only one of ten New York City AIDS cases is in foreign-born individuals. These numbers may reflect an underestimate of the actual number of foreign-born who are affected as many may fear being identified when seeking services, including HIV counseling and testing. In data on AIDS cases diagnosed through December 1997, foreign-born people with HIV total more than 11,000 cases from 150 countries, the majority, persons of color. There are no data on whether HIV infection was acquired in the U.S. or country of origin and for many people risk is unknown.<sup>72</sup>

*Through September 30, 1999, there were more than 110,000 cumulative cases of AIDS in New York City, more than the next four largest cities combined (Los Angeles, San Francisco, Miami and Washington).*

# Current HIV/AIDS Funding and Services

## NEW YORK STATE FUNDING AND SERVICES

The New York State Department of Health AIDS Institute, established by legislative mandate in 1983, has recognized since the start of the epidemic that specifically designed HIV/AIDS service models are required to meet the needs of geographic areas, communities, racial and ethnic groups, subpopulations within these groups, substance users, gay/bisexual men, women, young people, and other particular populations such as inmates, immigrants, the homeless, and the mentally ill. Regardless of a program's primary focus, given the epidemiology of HIV/AIDS, there is no program that does not in some way serve people of color.

The **Multiple Service Agency (MSA) Initiative** was established in 1992 specifically to enable existing minority organizations to expand infrastructure and capacity to deliver HIV services and to help coordinate community responses to AIDS. To be eligible for MSA funding, an organization must primarily serve communities of color, be located in areas with high concentrations of at-risk individuals, provide culturally sensitive services, and have a board of directors and staff who are representative of the affected communities. Thirty-four MSA programs provide services to high risk youth, homeless men and women living on the street and in shelters, Hispanic families, Native Americans, Asians and Pacific Islanders, Caribbean women, men who have sex with men, and transgender and other populations that might not readily use traditional health care programs. Total funding is \$11 million.

The **Community Development Initiative (CDI)** further expanded this effort by identifying organizations with strong HIV/AIDS expertise and ability to work collaboratively with other providers. CDIs have developed AIDS Leadership Coalitions consisting of community leaders representing HIV affected populations. The thirteen CDI agencies address either a geographic region or a population or both, working with all types of communities of color, and with men who have sex with men, substance users, adolescents, young women with children, and others. Total funding is \$2.3 million.

*Focus groups can help providers design programs to meet specific needs.*

Dina Wilcox  
New York State HIV  
Prevention Planning Group

*Newly arrived immigrants have varying levels of knowledge about HIV. The use of federal means tested programs can jeopardize immigration status. Immigrants will therefore forego the use of health care.*

Yvonne Graham  
Caribbean Women's Health  
Association



The **Substance Abuse Initiative**, developed in 1989, provides comprehensive HIV prevention and primary care services in substance abuse treatment settings of all kinds throughout New York State. In 1992, the Institute also established the Harm Reduction Initiative, which utilized emergency regulations allowing the creation of syringe exchange programs within a comprehensive harm reduction model. In addition to obtaining clean needles, clients of these programs learn methods to reduce the risk of HIV infection to themselves and their partners and obtain information about HIV counseling and testing, drug treatment, primary health care, HIV treatment, and other services. Total funding is \$14.5 million.

The **Gay, Lesbian, and Bisexual HIV Initiative** began in 1994, providing prevention education and services to men and women who have same-gender sex whether they identify as gay or not. Total funding is \$2.7 million.

**HIV prevention and health care services** are provided in a variety of settings (community-based organizations, county health departments, community health centers, hospitals, and clinics.) There are specialized programs for adolescents and young adults, women, children, families, the homeless, inmates, provider training, nutrition, support services, evaluation, and development of HIV treatment standards. In all the Institute lists more than 50 initiatives, each consisting of many programs, as well as other activities designed to educate individuals, groups, providers, and organizations, prevent HIV infection, treat those already infected, monitor the epidemic, and coordinate services.

The Institute convenes or works closely with 33 other committees and groups, including the New York State and New York City HIV Prevention Planning Groups, the Ryan White HIV Care Networks, the Statewide AIDS Service Delivery Consortium for Special Populations (SASDC), the New York City Department of Health, the New York State Interagency Task Force on HIV/AIDS, and the New York State AIDS Advisory Council.<sup>73</sup>

*Many churches and mosques are becoming very involved in HIV/AIDS services, expanding HIV testing, developing AIDS programs, and distributing condoms. But no aggressive tactics have been used for AIDS prevention.*

Pernessa Seele  
Balm in Gilead

*Often HIV education is not delivered in schools or is ignored by students. Other peer-oriented strategies are needed. HIV prevention should begin before adolescence.*

Joyce Hall  
Greater Brownsville Youth  
Council

For fiscal year 1999-00, total AIDS Institute funding is \$338 million derived from the State, CDC, Ryan White Title I, Title II, and other ancillary federal funds. Funds for HIV services are also administered by other state agencies.<sup>74</sup> Of all funds expended for direct services through contracts and health care programs for the uninsured (\$250.3 million), \$49.4 (20%) is for HIV prevention, and \$200.9 million (80%) is for health care and support services. This proportionate allocation results from significant increases over the last several years for the AIDS Drug Assistance Program (ADAP), while prevention funding has remained constant.

*Total AIDS Institute funding for fiscal year 1999-00 is \$338 million.*

Charts detailing distribution of all AIDS Institute direct service contract funding for fiscal year 1999-2000 by geographical area and percent of persons of color served were provided to the Council. Regions are New York City, Long Island, Hudson Valley, Northeastern New York, Central New York, Southern Tier, Rochester, and Western New York.

Figures indicate that the percent of total AIDS Institute contract funding (direct service funding) meets or exceeds the percent of persons living with AIDS (PLWA) in all areas except New York City, where substantial additional funding for HIV/AIDS is administered through the New York City Department of Health.

*Statewide for more than 300 of 466 HIV/AIDS contracts, people of color represent 75 to 100 percent of the caseload.*

In 1990, the AIDS Institute developed the Community Need Index (CNI) to assist HIV prevention programs in identifying communities in need of HIV prevention resources. The CNI calculates a composite score for each zip code based on ten indicators, including AIDS/HIV infection rates and other data related to low birthweight, teen pregnancy, substance abuse, and sexually transmitted diseases. A zip code's composite score is translated into a designation of high, moderate, or low prevention need. Maps are prepared based on CNI scores showing areas of HIV/AIDS prevention service need in relation to location of AIDS Institute contract providers, accompanied by lists of contract providers and the services they render.<sup>75</sup> Statewide, for 377 of 466 contracts, people of color represent 75 to 100 percent of the caseload.<sup>76</sup> Other tools for assessment include the Statewide Coordinated Statement of Need, which provides a comprehensive review of service requirements.

The **New York State Drug Assistance Program (ADAP)**, provides free HIV medications to uninsured or underinsured people with HIV. The New York State program has the largest drug formulary of any state in the country.

Data from 1987 through September 30, 1999 indicate increasing utilization by people of color and decreasing use by whites. Comparing enrollment in 1990 with that in 1999, the proportion of African Americans has increased from 24 percent to nearly 44 percent, of Hispanics from 28 percent to over 32 percent, and of Asians/Pacific Islanders from under .8 percent to 1 percent. Enrollment by Native Americans has fluctuated without a consistent trend between .1 percent and .4 percent, while whites have decreased from over 43 percent to under 19 percent.<sup>77</sup> Combination antiretroviral therapy has increased for all groups of enrollees in the ADAP program to 80 percent or better.<sup>78</sup>

*Use of combination antiretroviral therapy has increased to 80 percent or better for enrollees in all racial/ethnic groups of the New York State AIDS Drug Assistance Program.*

**Table 4. Enrollment in the AIDS Drug Assistance Program (ADAP) by racial/ethnic group and year, New York State.**

Race/ Ethnicity	1987	1990	1999
White, non-Hispanic	70%	43.5%	18.6%
African American	10%	24.1%	43.6%
Hispanic	16.4%	27.9%	32.5%
Asian/PI	2.1%	.8%	1%
NA/AN	0%	.4%	.2%

In addition, the **ADAP Plus program** covers the full range of HIV primary care outpatient services, and the **HIV Home Care Uninsured Program** provides skilled nursing, homemaker, home health aids, and other services.

## NEW YORK CITY FUNDING AND SERVICES

The Council was provided with materials by Mr. David Hansell, Associate Commissioner for Health for HIV Services in the New York City Department of Health, detailing New York City funding through the Bureau of Ryan White Care Services and the Bureau of HIV Prevention. Total funding is about \$130 million (\$104 million for Ryan White and \$28 million for prevention programs).

*Total funding for New York City HIV/AIDS services is \$130 million.*

A wide range of medical, social, and support services are funded through Ryan White from the Health Resources and Services Administration (HRSA). About half of the funds are distributed directly through a competitive process to community organizations. Between a fourth and a third go to the Uninsured Care programs operated by the AIDS Institute (ADAP, ADAP Plus, and Home Care). Funds that go to other AIDS Institute programs are also distributed to community organizations. About \$6.4 million of Ryan White funding is used for New York City agencies, such as health, corrections, human rights, and human resources, especially the Division of AIDS Services, which also redistributes funds to community organizations.

In 2000, the New York City Department of Health Ryan White Title I Program received substantially increased funding through a Congressional Black Caucus program. These funds will be used to improve health among HIV-infected people in communities of color: African Americans, Hispanics, Asians/Pacific Islanders, and Native Americans/Alaskan and Hawaiian Natives. Specifically, the Ryan White Planning Council has developed seven service priorities: enhancing access to care and early intervention, improving health care maintenance (both program continuations), and new initiatives addressing treatment education, treatment adherence, transitional housing and supportive services, transitional housing for prison releasees, and development and maintenance of organizational capacity.

There are two funding sources for prevention activities: the Centers for Disease Control and Prevention (CDC) provides approximately \$18 million, and \$10 million is allocated by the City from tax revenues. About \$11 million of this \$28 million total is used for contracts with community organizations, \$5.5 million for counseling, testing, and partner notification, \$3.4 million for health education/risk reduction by the department, \$2.8 million to other agencies for harm reduction, and other funds are directed to training, public information, and administration.

The New York City Department of Health works in concert with the New York City HIV Prevention Planning Group (PPG) in developing HIV prevention priorities. In 1998 and early 1999, the PPG developed a new prioritization strategy, called the Risk Targeting Model, which explicitly incorporates race and ethnicity as factors in determining the use of HIV prevention resources. The Department is now engaged in a multi-year effort to align program development and funding with this model.

*The Risk Targeting Model explicitly incorporates race and ethnicity as factors in using HIV prevention resources.*

Four new community-based HIV prevention initiatives will provide services for people of color.

Begun in 1999, the **Prevention Case Management Initiative** targets injecting drug users, other substance users, and their sexual partners. It provides intensive, one-on-one prevention counseling and support, as well as a continuum of related services. Ten agencies will be funded through this program.

New York City is currently implementing the **Prevention Collaboration Initiative** targeting African American and Hispanic communities and organizations. It will involve two projects for women at risk for heterosexual HIV transmission, providing outreach and a range of individual, group, and community-level interventions.

The **Peer Training Institute Initiative** will renew a highly successful program targeting a range of high risk, underserved populations. A lead agency will primarily have training and evaluation responsibilities, while collaborating agencies will provide peer interventions.

The recently released **Multi-Module RFP** seeks to fund programs targeting six population groups: people at risk for HIV through injection drug use and sexual behavior, men who have sex with men, women, people involved with the criminal justice system, youth and young adults, and HIV-positive individuals. Programs will provide outreach, prevention case management, and other interventions at the individual, group, and community level.

Since need actually varies considerably within racial categories and geographic areas, more sophisticated assessment methods are being developed. The City is also investigating ways to more specifically target services once need is determined, especially determination of risk.<sup>79</sup>

Among new clients in the Ryan White CARE Act programs administered by New York City in 1997-98, people of color exceeded their proportions in the AIDS population (46% of new clients were African American, 39% Hispanic, 12% white, and less than 1% were Asian/PI/Native American). A chart was provided detailing percentages of services by borough, showing fewer Ryan White clients in areas where people with AIDS are more likely to have private insurance.<sup>80</sup>

New data presentation methods are being developed to enable better comparison of need with provision of services, including those that are privately funded, as well as better monitoring of resource allocation and program coordination.<sup>81</sup>

*Among new clients in the Ryan White CARE Act programs administered by New York City in 1997-98, people of color exceeded their proportions in the AIDS population: 46 percent of new clients were African American, 39 percent Hispanic, 12 percent white, and less than 1 percent were Asian/Pacific Islander/Native American.*

# Strategies for Communities of Color

Clearly, given the burden of HIV/AIDS in communities of color, resources and creative thought must be directed to the development and implementation of strategies that will most effectively counter this crisis. Despite the decline in AIDS deaths among all risk groups, high rates of new HIV infection persist among people of color. With more HIV affected people living healthier, sexually active lives, there is an even greater need for improved HIV prevention and treatment services.

Some general recommendations have been proposed by the Centers for Disease Control and Prevention (CDC) and many of the speakers at New York State AIDS Advisory Council meetings had specific ideas for the communities they know best. Presenters stressed both increased communication of information about proven approaches and the development of new skills for greater effectiveness. The New York State Department of Health AIDS Institute and the New York City Department of Health Division of HIV/AIDS Services have, since the early years of the epidemic, designed programs and directed substantial funding specifically to reach people of color with HIV prevention and treatment services.

## CDC RECOMMENDATIONS

In its summary of issues for **African Americans**, the CDC notes “It is clear that the public sector alone cannot successfully combat HIV and AIDS in the African American community. Overcoming the current barriers to HIV prevention and treatment requires that local leaders acknowledge the severity of the continuing epidemic among African Americans and play an even greater role in combating HIV/AIDS in their own communities.” Regarding **Hispanics**, “Because the HIV/AIDS epidemic...reflects to a large extent the exposure modes and cultural modes of the individuals’ birthplaces, an understanding of these behaviors and differences is important in targeting prevention efforts.” Specifically, for both African Americans and Hispanics the CDC recommends comprehensive programs to reduce both injection-related and sexual risks among drug users, integration of HIV prevention and treatment with substance abuse and STD programs, and improved, sustainable prevention activities for young gay men.<sup>82</sup>

*“It is clear that the public sector alone cannot successfully combat HIV and AIDS in the African American community. Overcoming the current barriers to HIV prevention and treatment requires that local leaders acknowledge the severity of the continuing epidemic among African Americans and play an even greater role in combating HIV/AIDS.”*

Centers for Disease  
Control and Prevention

To combat **injection drug use**, the CDC recommends that interventions be aimed at reducing high risk sexual behavior, preventing the initiation of drug injection, improving access to drug treatment programs, instituting HIV prevention programs in jails and prisons, and providing HIV counseling, testing, and treatment for IDUs and their partners. Drug abuse treatment should be thought of as an HIV prevention strategy. However, "For injection drug users who cannot or will not stop injecting drugs, using sterile needles and syringes only once remains the safest, most effective approach for limiting HIV transmission."<sup>83</sup>

There are from 325,000 to 475,000 **gay and bisexual men** living with HIV in the U.S. Evidence of a resurgence of unsafe sex among them and a 1999 study indicating that degree of complacency is correlated with optimism about new treatment advances, argue for renewed efforts to provide information and develop skills to maintain safe sex behavior, especially to young men and men of color.<sup>84</sup>

Since many cases of HIV/AIDS in **women** are reported with unknown cause, many women may be unaware of their sex partner's risk factors, or providers are not sufficiently documenting the risks for women. More than two-thirds of AIDS cases in women with unknown risk factors were later reclassified as heterosexual transmission. Prevention programs are needed for infected and uninfected women, especially young women and women of color. Women who use drugs, have sex for money or drugs, or have sex with drug using partners are at particular risk. Women in relationships they believe to be monogamous and women who cannot or will not require condom use with a male partner urgently need other options. Female condoms are available and are being evaluated for HIV prevention, while research continues on microbicides and other female-controlled protection methods.<sup>85</sup> Women also require better integration of HIV and primary care prevention and treatment services for themselves and, since they are most often caregivers, for family members, as well as child care, future care and custody services, and other family-centered programs.

The alarming rate of HIV infection in **young people** (at least half of new infections) and the fact that AIDS deaths in people 25 to 44 reflect HIV infection during adolescence together point to a need for immediate and substantial expansion of HIV prevention programs for youth. The especially high rates of new infection among young women of color are of great concern. Recent trends toward a decline in sexual activity and increased use of condoms among high school students indicate that prevention programs, especially those

*Drug abuse treatment should be thought of as an HIV prevention strategy. However, "For injection drug users who cannot or will not stop injecting drugs, using sterile needles and syringes only once remains the safest, most effective approach for limiting HIV transmission."*

Centers for Disease Control and Prevention.

*In a recent survey of men who have sex with men, 10 percent of blacks, 8 percent of Latinos, 4 percent of Asian/Pacific Islanders, and 3 percent of whites admitted to having unprotected sex with a woman in the past year.*

Dr. Tracy Mayne  
New York City  
Department of Health  
HIV/AIDS Prevention



emphasizing both delaying sex and protection, can have impact. "CDC research has shown that early, clear communications between parents and young people about sex is an important step in helping adolescents adopt and maintain protective sexual behaviors." In addition, school and community programs to reach young people in and out of school, programs for gay and bisexual youth, drug abuse prevention, and STD education and treatment are needed. HIV services should be integrated with other health topics such as pregnancy, sexually transmitted diseases, tobacco, drugs, nutrition, and physical activity.<sup>86</sup>

## **AIDS ADVISORY COUNCIL PRESENTATIONS AND DELIBERATIONS**

From May 1999 to January 2000, following two presentations on New York City and New York State HIV/AIDS funding in November and December of 1998, the Council devoted a portion of nearly every meeting to discussions and presentations about HIV/AIDS in communities of color. A list of these speakers, representing a wide variety of organizations and affected populations, is included at the end of this report, along with a summary of their presentations. Some speakers provided written statements, which are available on request. Presentation summaries (Appendix I) should be consulted for additional suggestions specific to various populations and geographic areas.

The final Principles and Recommendations concerning HIV/AIDS in communities of color that were adopted unanimously by the Council in January 2000 conclude this report. The Council agrees with affected populations that this issue is of paramount importance to the overall health, welfare, and indeed survival, of these populations and ultimately of entire communities. Reducing rates of HIV/AIDS in communities of color is a matter of great urgency. Preventing HIV and AIDS should be one of the highest public health priorities, accorded increased funding and serious attention by legislators, health administrators, and providers.

Although increased funding is essential, it is not all that is needed. Among the major tasks is the development of expanded partnerships with community leaders and organizations willing to take on the vital work of helping to design and implement new strategies for combating HIV/AIDS. The Council is firmly committed to the idea that "top down" and "bottom up" efforts must meet and coalesce into focused, culturally appropriate campaigns that have

*There is a great need for places where young people can come to talk to each other and get information and condoms. They deserve honest answers and respect for their ability to negotiate their lives.*

Ralph Mutis  
Bronx Youth in Action,  
Hispanic AIDS Forum

*All young people should have the knowledge, skills, and social support necessary to protect them from infection. Key decision makers should have access to data about harm reduction and other critical issues. Many organizations have large stores of information. Sharing it has, in fact, improved prevention services.*

Michael Ezie  
Blue Cross/Blue Shield of  
Western New York

credibility with affected populations and proceed with determination to change the course of epidemic. Researching and incorporating new health education approaches and methods to effect behavior change and fostering consensus and momentum around these strategies are indispensable.

The Council highlighted seven essential elements for improved HIV/AIDS prevention and services for communities of color:

- Recognition of the urgency of the problem
- Community engagement
- A strong emphasis on HIV prevention
- Specific attention to high risk populations
- Racial and cultural sensitivity
- A continuum of care
- A comprehensive approach, recognizing that HIV/AIDS is part of a larger constellation of health and social problems in the lives of many people of color.

These essential elements became the principles on which the Council's recommendations are based. Each of the seven final recommendations are accompanied by a number of specific action steps to encourage rapid implementation. The overriding recommendations call for the following:

- A broad-based campaign to describe the extent and urgency of the problem
- Adoption of HIV prevention in communities of color as one of the highest public health priorities
- Increased funding and resources, particularly for HIV prevention
- Coordination of strategic planning through partnerships and coalitions
- A strategic plan that includes education and training about prevention methods, improved access to services, and extensive treatment education, all utilizing methods that are specific to communities of color and adaptable to individual circumstances and needs
- Specific initiatives to reach groups with a particularly high or growing risk of infection
- The fullest possible use of existing organizations, programs, and health systems.

*It is not enough to meet and discuss the problem and exchange statistics. There should be public meetings and education of legislators and, most important, development of an action plan.*

Debra Fraser-Howze  
National Black Leadership  
Commission on AIDS

In addition to its focus during the past year on HIV/AIDS in communities of color and the development of this report, the Council has in the past examined many of the issues pertinent to specific populations in some depth and has issued reports throughout the HIV epidemic with detailed recommendations for legislative, public health, and community initiatives.

The Council supports harm reduction strategies that educate IV drug users about the dangers of reusing needles, syringes, and other injection equipment. The Council's 1998 report on needle exchange programs cited evidence that these programs do not increase drug use among confirmed users or encourage others to initiate it, but rather are important venues for HIV prevention and drug treatment information and referrals. The report concluded that these programs should be expanded and the purchase of needles and syringes without prescription should be legalized in New York State.

The Council's 1989 and 1999 reports on *HIV/AIDS in New York State Correctional Facilities* chronicled inadequacies in HIV services for inmates, who are overwhelmingly African American and Hispanic with high rates of HIV infection. The 1999 *Report of the Workgroup on Ethical Issues in Access to HIV Treatment* outlined a new paradigm of HIV care that could enable individuals whom providers might assume to be unable to maintain HIV treatment regimens to benefit from effective new therapies if given appropriate support services and continuity of care. These individuals include injection drug users, inmates, immigrants, the mentally ill, adolescents, and children. Other reports, such as those on newborn HIV screening, adolescents and HIV, and HIV/AIDS prevention in sex clubs, addressed the needs of specific populations at high risk of HIV infection. Providers have also issued corollary reports, such as the 1996 publication by the Federation for Protestant Welfare Agencies, titled *Families in Crisis*, which detailed the need for ongoing permanency planning services for the care of children whose parents are incapacitated by HIV/AIDS.

*In the Hudson Valley, there is a lack of culturally and linguistically appropriate programs for growing numbers of seasonal and migrant workers and immigrants. Many groups are geographically isolated.*

Julia Andino  
AIDS-Related Community  
Services

*What about the changing dynamics of familial situations and children's needs at different ages? Providers and funders must understand that future care and custody is an ongoing process and still a serious, widespread problem.*

Mildred Pinott, Esq.  
Legal Aid Society

## THE FUTURE OF HIV/AIDS IN COMMUNITIES OF COLOR

AIDS was not a disease of gay white men and it is not now a disease of people of color. However, acknowledging the devastation of HIV infection in communities of color and giving serious consideration to why this is taking place and what can be done to stop it are the necessary initial steps to change.

AIDS cases among people of color exceeded cases among whites from the earliest years of the epidemic. The crisis is rapidly growing and now constitutes one of the most urgent health problems in communities of color. Race and ethnic background have and must be taken into account in developing ethically and medically responsible service models. Ethnicity affects every aspect of HIV prevention and treatment: the types of barriers to services, the strategies necessary to overcome them, even the definition of care itself. In communities of color, HIV cannot be discussed in a vacuum, but must be seen within the context of many other health and social problems.

Although communities of color must work actively to meet this challenge, the problem cannot and should not be solved by people of color alone. All communities must become involved in preventing HIV among all people.

New partnerships require a foundation of trust and a consensus for action. Forging these is a demanding and imperative business. Finding strategies that will produce results quickly and efficiently requires openness to new ideas and research into the most current health education and behavior change strategies. This is also a difficult and uncertain task.

The New York State AIDS Advisory Council, in undertaking this report, is issuing a call to action. All communities must commit themselves to implementing the recommendations set forth in this report. Fear of AIDS has kept many people silent and allowed the infection to spread. Fear must not keep people from finding solutions.

*HIV/AIDS constitutes one of the most urgent problems faced by people of color. Although communities of color must work actively to meet this challenge, the problem cannot and should not be solved by people of color alone. All communities must become involved in preventing HIV among all people.*

*Fear of AIDS has kept many people silent and allowed the infection to spread. Fear must not keep people from finding solutions.*

# **HIV/AIDS in Communities of Color**

## **Principles and Recommendations**

### **Principles**

The following principles are meant to serve as the foundation upon which a strategy for reducing HIV/AIDS in communities of color can be built.

**1. RECOGNITION OF URGENCY**

Public and professional recognition of the dramatically disproportionate numbers of people of color infected with and affected by HIV/AIDS and development of new strategies to address this "severe and ongoing health care crisis" (in the words of the President), should become a public health priority of the utmost urgency.

**2. COMMUNITY ENGAGEMENT**

Multi-level community involvement, leadership, and shared purpose are fundamental to any significant improvement in HIV/AIDS prevention and care in communities of color.

This includes development of successful working relationships with and among community organizations, institutions, service providers, people at risk for, or living with, HIV, and leaders recognized as such by communities (not only those formally appointed). It requires an emphasis on peer services, the participation of all groups in planning and implementing programs, technical assistance and infrastructure support to build strong community agencies, and enlisting the commitment of all participants to common goals. Infrastructure support and capacity-building assistance, including leadership development and technical assistance, are prerequisites for meaningful participation by most grassroots community-based organizations.

**3. EMPHASIS ON PREVENTION**

To make the best use of existing and new resources and in recognition of the enormous social and economic cost of every case of HIV, efforts must focus on prevention of new HIV infections, while continuing to ensure appropriate care for those infected.

This involves analysis and implementation of diverse types of prevention strategies likely to be most effective in the various communities of color. It also requires integrating a strong prevention component into the traditionally treatment-oriented health care system.

**4. SPECIFIC ATTENTION TO HIGH RISK POPULATIONS**

It is essential to tailor messages and strategies not only to communities in general but also to those particular subgroups within communities of color thought to be at highest risk for HIV infection or those most difficult to reach with prevention information, treatment, and support services.

These groups include particularly: substance users, men who have sex with men, women, children and young people (in and out of school), immigrants, inmates, and those newly released from prison. Also, many other groups, such as the mentally ill and homeless, and many risk factors, such as prostitution, should receive targeted attention.

**5. RACIAL, ETHNIC AND CULTURAL COMPETENCY**

Programs and services in communities of color should be designed in accordance with a sophisticated understanding of racial, ethnic and cultural differences. This is essential both for effective outreach and service provision and for forging mutually respectful partnerships.

This includes but is not limited to recognition of variations in values and beliefs emanating from race, religion, gender, age, class, or sexual orientation; and cultural variations that derive from language, country of origin, or alternative medical care beliefs and practices.

**6. CONTINUUM OF CARE**

People of color should have access to a full continuum of high-quality HIV/AIDS services from outreach and education through counseling, testing, treatment, long-term care, and terminal care. Efforts must recognize that achieving access is as dependent on engaging, supportive attitudes of culturally sensitive staff and facilitating resources, such as transportation and child care, as it is on the location and funding of programs.

This requires integration of efforts by funding agencies, program planners, and service providers. It involves enhanced vertical and horizontal communication, partnerships, data-sharing, co-located services (for example, for health care and substance use treatment), and expanded referral networks, training at all levels, infrastructure support and development and processes to ensure the quality of services.

**7. CORRELATION OF HEALTH AND SOCIAL ISSUES**

HIV/AIDS must be seen as part of a larger constellation of health, economic, political, and social issues in communities of color that are intimately and inescapably linked. These issues contribute to a high risk of HIV, and high rates of HIV infection in turn de-stabilize families and communities. Efforts to reduce HIV incidence should stress a comprehensive approach to promoting health and preventing disease, and they should contribute as much as possible to reducing social and environmental risk factors.

Social and environmental risk factors include those which are health-related (such as chronic disease, violence, substance use, and sexually transmitted diseases), as well as those which contribute to community deterioration (such as poverty, family disintegration, inferior schools, and lack of housing, employment skills, and opportunities). A comprehensive approach to health promotion recognizes the existing significant racial disparities in all types of health care, and, consequently, in health indices, and works to integrate HIV services with other measures to promote wellness in individuals, families, and communities.

## Recommendations

1. **Federal, state and local health officials, community leaders, and community-based service providers should undertake a wide-spread campaign to describe the extent and urgency of the HIV/AIDS crisis in communities of color, presenting it as a severe and ongoing health crisis requiring immediate, serious, and sustained attention.**

### Action Steps

- a. Public information tools (such as press releases, interviews in various media, data sheets, newsletter bulletins, and public service announcements, public transportation advertising, billboards, and posters) should be employed to raise consciousness about the extent and urgency of the HIV/AIDS crisis in communities of color.
  - b. Public officials should be encouraged to discuss this crisis and maintain focus on it in their regular contacts with the media, funding agencies, and community and professional groups (including other health and non-health related government agencies, providers, and community organizations).
  - c. Special efforts should be made to educate all federal, state, and local legislators. This should include meetings with elected officials, staff members, and leaders of legislative groups representing the interests of people of color.
  - d. The campaign should acknowledge existing disparities in health indices as evidence of the range of other community problems that contribute to high rates of HIV in communities of color.
  - e. This report should receive wide distribution.
2. **Public health officials at all levels, community leaders, and community-based service providers should establish prevention of HIV in communities of color as one of their highest priorities.**



### Action Steps

- a. Numerical goals should be established for the reduction of HIV incidence and HIV-related risk behaviors in all populations, including communities of color, with the goal of eliminating racial/ethnic disparities in the context of over-all reductions in all groups.
  - b. Health officials and community-based providers should ensure that a strong focus on HIV prevention is integrated into all primary care, HIV-related, and other appropriate programs and services in communities of color, including especially those concerned with youth, substance users, women, children, inmates, and immigrants.
  - c. The New York State Department of Health should work with other state, local, and federal agencies to elicit a commitment for a collaborative official approach on this issue.
  - d. The New York State Department of Health should identify and aid official and unofficial community leaders to mobilize all segments of the community to adopt HIV prevention as both an immediate and a long-range goal.
3. **Elected officials and public health agencies at the federal, state, and local levels, private foundations, and other funders, together with community leaders, should make increased public and private funding for HIV prevention a top priority. This is essential to achieve a measurable reduction in HIV infection rates and in HIV morbidity and mortality in communities of color. Funding allocations should take a broad view of factors contributing to the disproportionate effect of the HIV epidemic on people of color and should direct funds to programs that are most likely to make a contribution toward reducing this disparity.**

### Action Steps

- a. The New York State AIDS Advisory Council (through the recommendations of its Budget Subcommittee), and health officials should advise funders and legislators of the social and economic cost of NOT preventing HIV infection.

- b. The State Legislature and local legislative bodies should increase funding for HIV prevention, particularly targeted at communities of color and adolescents.
- c. The New York State Department of Health and local health departments should work with other partners to educate the New York Congressional delegation and other key members of Congress about the need for additional prevention funding.
- d. Funders should insure that every agency directly providing health services or having an impact on health concerns has sufficient resources -- including program funds, staff, and training -- to take the steps necessary to achieve measurable reductions in HIV in communities of color. Relevant state agencies include the Department of Health AIDS Institute and Office of Minority Health, Office of Alcoholism and Substance Abuse Services, Office of Mental Health, Office of Children and Family Services, Department of Correctional Services, Division of Parole, and Division of Probation and Correctional Alternatives. Other key agencies include those that focus on social, economic, and educational services, such as the Department of Education and the Department of Temporary and Disability Assistance, as well as local public health and social services agencies. Thus, funding should address issues such as (but not limited to) improving access to primary care in underserved areas; HIV education for children and youth in foster care, shelters, or juvenile detention; HIV materials for school-based clinics; HIV prevention in prisons and discharge planning programs; supporting the infrastructure of minority organizations that integrate HIV prevention within their services; assuring food and shelter to avoid prostitution; and any other avenue for reinforcing an intense and comprehensive campaign to reduce HIV infection.

- e. To make the most efficient use of existing resources, health officials should expand evaluation of current HIV prevention program models to assess effectiveness and make appropriate changes in program design and resource allocation. Recognizing that race is one of the strongest predictors of HIV risk, assessments should utilize tools such as the New York State Department of Health Community Need Index and should focus not only on geography, but on barriers to service, cultural accommodation of populations served, and demonstration of impact.
4. **State and local health departments, community leaders, health care providers, and a wide range of community organizations and representatives from affected communities should establish partnerships and a mechanism of oversight to coordinate strategic planning, determine time-tables, and promote and monitor efforts to achieve HIV prevention and related health care goals.**

#### **Action Steps**

- a. The urgency of the HIV crisis in communities of color demands that existing partnerships be strengthened and that new alliances be created as soon as possible. The purpose is to build momentum for substantive change in HIV infection rates and utilization of health care, as well as increased awareness of the social and economic value of health promotion in general. Many types of partnership and interaction should be utilized to achieve the broadest possible commitment to goals.
- b. Organizers should enlist the participation of organizations that are part of the fabric of communities (such as faith-based networks, business and civic groups, consumer associations, schools, hospitals, clinics, shelters, and community action agencies), to assume leadership roles in raising HIV awareness and in attaining primary prevention and other HIV-related goals. To ensure participation from a broad range of community groups and organizations and not jeopardize already vulnerable service

- capabilities, it is imperative to ensure adequate leadership development, technical assistance, infrastructure development and capacity building.
  - c. Planners should recognize that without substantial consensus and time-tables, change will not occur. Planners should thus seek to create an environment for establishing common goals, should specify concrete steps appropriate to each group, should elicit pledges for action, and should establish a system of accountability so that specific activities can lead to measurable change.
- 5. **A strategic plan to counter the HIV/AIDS crisis in communities of color should seek to disseminate epidemiological information to form the basis of a planning process and to establish a comprehensive approach to HIV prevention and treatment. This approach must encompass education and training about prevention methods; access to high-quality medical and social services; and patient and provider education about treatment options, clinical trials, and treatment maintenance. It must utilize wherever possible proven strategies specific to each community of color.**

#### **Action Steps**

- a. Health officials, academicians, and community-based providers should identify the core elements of effective HIV prevention and should expand efforts to implement those HIV prevention strategies that are particularly effective in communities of color, using the most current information from research on methods to effect health behavior change. Strategies known to be effective (including comprehensive harm reduction for substance users and peer-delivered outreach and prevention education) should be emphasized.
- b. Strategic planning partners should help to identify strategies for improved HIV prevention and health care specific to racial and ethnic groups. These may involve social

- marketing designed specifically for communities of color, greater interagency collaboration, and educational activities to empower communities to take a leadership role.
- c. Training curricula should sensitize program directors and providers to the multiple definitions of "community" and multiple cultural traditions within even a single self-defined community.
- d. Programs should strive to hire and train people who are part of the community being served, who speak the language of the population being served, who understand the cultural backgrounds of those being served, and who can help to design and utilize effective education methods. Program managers should ensure that their staff recognize and respect individual and community cultural values and should develop and implement a process to assess cultural competency. This includes recognition of the use of alternative medicine, widespread among some groups, and specific focus on the distrust that many people harbor toward mainstream health providers, therapies, and information about HIV.
- e. Face-to-face translation services and educational materials written in appropriate languages should be available in every service setting.
- f. Agencies should be given the tools to use creative, age-appropriate (including for adolescents and senior citizens), clear and explicit prevention messages most likely to have maximum impact. Technical assistance and infrastructure development support to community organizations should be readily available and utilized to enhance program effectiveness.

- g. Health officials, providers, and community organizations should analyze data as well as anecdotal reports about gaps in, and barriers to, service so that programs can be adjusted accordingly.
  - h. Providers should be trained in methods that support the initiation of combination therapy and improve the probability of maintaining treatment regimens (for example, by coordinating referrals for social services and exploring workable medication schedules with the patient).
6. **Strategic planning for campaigns to reduce HIV infection rates, morbidity and mortality in communities of color should also specify initiatives to reach groups with a particularly high or growing risk of infection. These include: injection drug users; sex partners of injection drug users; men who have sex with men; women; youth; children; the mentally ill; prison inmates; ex-offenders; immigrants; and migrant workers.**

**Action Steps**

- a. Programs serving communities of color should determine how their services might be customized for each of these groups, and programs designed to serve these groups should determine how services might be better adapted for people of color. Programs targeting youth under 25 years of age should receive particular emphasis.
- b. Programs should be designed for, and staff should be trained for, the probability that people will fall into many categories simultaneously and have multiple, complex needs that require targeted, customized outreach and service coordination. For example, a substance-using adolescent of color may also be truant and concerned about immigration problems. A mentally ill inmate of color about to be discharged may have no place to live and no means of support. Programs should thus be encouraged to expand their referral networks and emphasize continuity of care.

7. **Planners should make the fullest possible use of existing institutions, organizations, networks (formal and informal), and health care delivery systems; should review existing reports and materials; should expand interagency initiatives; and should seek to establish a consistent and pervasive focus on the goal of reducing HIV in communities of color.**

#### **Action Steps**

- a. Strategic plans should consider creative integration of HIV education and health promotion concepts into a wide range of settings, including: schools; after-school programs; shelters for youth and adults; hospitals, clinics, community health centers; private practice and medical groups; community-based organizations; managed care plans; maternal and infant care programs; substance abuse programs; faith-based activities; social service structures; the programs of civic, neighborhood, and business groups; and the work of groups serving African Americans/blacks, Hispanics/Latinos, Asians, Pacific Islanders, and Native Americans.
- b. In refining prevention strategies, planners should utilize and build on HIV Prevention Plans developed by the State and City community planning groups (PPGs).
- c. To help identify gaps in the HIV service continuum and to locate new program activities in areas of high and emerging need, planners should utilize the recently compiled Statewide Coordinated Statement of Need, the Health Care Service Delivery Plans developed by the New York State Ryan White HIV Care Networks, and the New York State Department of Health Community Need Index.
- d. In considering services for underserved populations, planners should consult the Statewide AIDS Services Delivery Consortium (SASDC) Special Populations Service Delivery Plan, which identifies the

needs of six populations: men of color who have sex with men; the homeless; prison releasees; immigrants; migrants; and people with the multiple diagnoses of HIV infection, mental illness, and substance use.

- e. Planners should encourage expansion of interagency and inter-organization activities, such as: joint projects undertaken by the AIDS Institute and OASAS, discussions of the Interagency Task Force on HIV/AIDS, and efforts by the Black Leadership Commission on AIDS, the Latino Commission on AIDS, the Asian/Pacific Islander Coalition on HIV/AIDS, the American Indian Community House, Action for a Better Community, Centro Civico of Amsterdam, the Federation of Protestant Welfare Agencies, Group Ministries, the Haitian Centers Council, the Hispanic Federation of New York City, J-CAP, the Long Island Minority AIDS Coalition, the Urban League of White Plains and other groups.
- f. Planners should review and utilize existing reports, such as those of the New York State AIDS Advisory Council on HIV in Adolescents, HIV/AIDS in New York State Correctional Facilities, the Report on HIV and Harm Reduction, and the Report of the Ethical Issues in Access to Treatment Workgroup.
- g. Program managers should utilize and build on AIDS Institute standards for evaluation of HIV prevention and HIV health care programs.
- h. Every effort should be made to insure the success of existing institutions and networks and the proliferation of new partnerships to reduce HIV in communities of color. Institutions should view individuals in the context of their lives and overall needs, and encourage them to make HIV prevention a priority and to seek testing and treatment. Planners should recognize that vigilance about HIV prevention and use of health care services must become part of both a personal and community commitment to health promotion.



# **Presentations to the New York State AIDS Advisory Council**

**November 1998 - December 1999**

**Mr. Larry Abrams**  
Gay Men's Health Crisis

**Ms. Julia Andino**  
AIDS-Related Community Services

**Mr. David Chen**  
Chinese-American Planning Council

**Dr. Mary Ann Chiasson**  
New York City Department of Health

**Dr. Henry Crevecoeur**  
Brownsville Multi-Service  
Family Health Center

**Mr. Dennis DeLeon**  
Latino Commission on AIDS

**Mr. John Egan**  
New York City Department of Health

**Ms. Verna Eggleston**  
Hetrick Martin Institute

**Ms. Cissy Elm**  
HIV/AIDS Project  
American Indian Community House

**Mr. Michael Ezie**  
Blue Cross/Blue Shield of Western New York

**Ms. Maria Favuzzi**  
New York City Department of Health

**Dr. Susan Forlenza**  
New York City Department of Health

**Ms. Debra Fraser-Howze**  
Black Leadership Commission on AIDS

**Ms. Patricia Gogol**  
Capital Region BOCES/APPLE Program

**Ms. Yvonne Graham**  
Caribbean Women's Health Association

**Ms. Joyce Hall**  
Greater Brownsville Youth Council

**Mr. David Hansell, Esq.**  
New York City Department of Health

**Ms. Karen Kelly**  
New York State Department of Health

**Dr. Tracy Mayne**  
New York City Department of Health

**Mr. Bruce Mesh**  
New York City Department of Health

**Mr. Rafael Mutis**  
Hispanic AIDS Forum

**Mr. Michael Nazarko**  
AIDS Institute  
New York State Department of Health

**Mr. Ravinder Patur**  
Medical and Health Research Association  
of New York City

**Ms. Mildred Pinott, Esq.**  
Legal Aid Society

**Mr. Leo Rennie**  
Harlem Directors Group

**Ms. Pernessa Seele**  
Balm in Gilead

**Ms. Judy Verdino**  
Medical and Health Research Association  
of New York City

**Ms. Wilma Waithe**  
Office of Minority Health  
New York State Department of Health

**Dr. Darrell Wheeler**  
Columbia University School of Social Work

**Ms. Dina Wilcox**  
New York State HIV Prevention Planning Group

**Ms. Monique Wright-Williams**  
Syracuse Model Neighborhood Facility

**New York State Department of Health  
AIDS Institute staff who contributed to this report:**

**Mr. Ken Colwill**  
Bureau of Community-Based Services

**Mr. John Cinque-Sacarello**  
Statewide AIDS Service Delivery Consortium

**Ms. Janet Foster**  
Division of HIV Prevention

**Ms. Bethsabet Justiniano**  
Bureau of Community-Based Services

**Mr. Dominick Boyce**  
Bureau of HIV Ambulatory Care Services

**Ms. Lisa Roland-Labiosa**  
Bureau of HIV Ambulatory Care Services

**Mr. John Leung**  
Office of Program Evaluation and Research

**Ms. Sonja Noring**  
Executive Office, Writer/Editor

**Ms. Wanda Jones Robinson**  
Bureau of HIV Ambulatory Care Services

**Ms. Sallie Perryman**  
Office of the Medical Director

**New York State Department of Health  
AIDS Institute staff to the AIDS Advisory Council:**

**Dr. Guthrie Birkhead**  
Director, AIDS Institute

**Ms. Gloria Maki**  
Executive Deputy Director, AIDS Institute

**Ms. Sonja Noring**  
Executive Office, Writer/Editor

**Ms. Andrea Small**  
Director, Office of Special Projects

**Ms. Mabel Pruden**  
Office of Special Projects

**Mr. Augie Corsi**  
Executive Assistant

## Endnotes

---

1. AIDS Epidemic Update: December 1999. Joint United Nations Programme on HIV/AIDS. p. 2
2. Centers for Disease Control and Prevention HIV/AIDS Surveillance Report: U.S. HIV/AIDS cases reported through June 1999. 11:1, p. 6.
3. *On the Front Lines: Fighting HIV/AIDS in African American Communities*. Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention. August 1999. p. 3.
4. *HIV/AIDS Among African Americans*. Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention, Divisions of HIV/AIDS Prevention. August 1999. p. 1.
5. New York State AIDS Surveillance Report data as of September 30, 1999. Table 1, 4A, 6D, and 7.
6. *Population Estimates for States by Race and Hispanic Origin: July 1, 1998*. Population Estimates Program, Population Division, U.S. Census Bureau.  
<http://www.census.gov/population/estimates/state/srh/srhus98.txt>
7. Presentation to the New York State AIDS Advisory Council by New York State Department of Health AIDS Institute staff. November 4, 1999.
8. AIDS Epidemic Update: December 1999. Joint United Nations Programme on HIV/AIDS. p. 3-4.
9. *Health Care Rx: Access for All*. The President's Initiative on Race. U.S. Department of Health and Human Services, Health Resources and Services Administration. p. 2.  
Loue, S. *Gender, Ethnicity, and Health Research*. 1999. p. 87.
10. *Health Care Rx: Access for All*. The President's Initiative on Race. U.S. Department of Health and Human Services, Health Resources and Services Administration. p. 3-9.
11. Satcher, D. *Highlights from the 1999 National Conference on African Americans and AIDS*.  
[http://hopkins-aids.edu/afam/afam\\_hilites/afam\\_17.html](http://hopkins-aids.edu/afam/afam_hilites/afam_17.html).
12. *Gender, Ethnicity, and Health Research*. Sana Loue. 1999. p. 87.
13. Rawlings, K. Expert Roundtable Consensus Meeting Transcript. The 1999 National Conference on African Americans and AIDS, September 14, 1999. p. 18.
14. Goosby, E. Expert Roundtable Consensus Meeting Transcript. The 1999 National Conference on African Americans and AIDS, September 14, 1999. p. 8.
15. "President Clinton: Protecting America's Health: Increasing Funding for HIV/AIDS," October 28, 1998. <http://www.whitehouse.gov/WH/Work/102898.html>.

16. *The Unequal Burden of Cancer: An Assessment of NIH Research and Programs for Ethnic Minorities and the Medically Underserved*. Haynes, MA, Smedley, BD (eds). 1999. This report asserts that traditional racial classifications (black, white, Native American/Alaska Native, and Asian/Pacific Islander) are “of limited utility for purposes of health research because the concept of race rests upon unfounded assumptions that there are fundamental biological and behavioral differences among racial groups.”
17. *The Challenge of HIV/AIDS in Communities of Color*. National Commission on AIDS. December 1992. p. 6-7.
18. Maldonado, M. *The HIV/AIDS Epidemic Among Latinos in the United States: Update*. National Minority AIDS Council. October 1998. p. 1.
19. Loue, S. *Gender, Ethnicity, and Health Research*. 1999. p. 117, 134.
20. Loue, S. *Gender, Ethnicity, and Health Research*. 1999. p. 101.
21. Ma, GX, and Henderson, G. *Rethinking Ethnicity and Health Care: A Sociocultural Perspective*. 1999.
22. *Health Care Rx: Access for All*. The President’s Initiative on Race. U.S. Department of Health and Human Services, Health Resources and Services Administration. p. 17.
23. Loue, S. *Gender, Ethnicity, and Health Research*. 1999, p. 102-7, 118-23, 135-6.
24. *HIV/AIDS Work Group on Health Care Access Issues for African Americans*. U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Bureau of Health Resources Development. February 22-23, 1993. p. 20-27.  
*HIV/AIDS Work Group on Health Care Access Issues for Hispanic Americans*. December 15-16, 1991. p. 11-13.
25. *HIV/AIDS Among African Americans*. Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention, Divisions of HIV/AIDS Prevention. August 1999.
26. *Resident Population Estimates by Sex, Race, and Hispanic Origin: April 1, 1990 to November 1, 1999*. Populations Projections Program, Populations Division, U.S. Census Bureau. <http://www.census.gov/population/projections/nation/intfile3-1.txt>.
27. *Projections of the Resident Population by Race, Hispanic Origin, and Nativity: Middle Series, 2025 to 2045*. Populations Projections Program, Populations Division, U.S. Census Bureau. <http://www.census.gov/population/projections/nation/summary/nnp-t5-f.txt>.
28. Campbell, PR. *Population Projections for States by Age, Sex, Race, and Hispanic Origin: 1995 to 2025*. 1996. Populations Projections Program, Populations Division, U.S. Bureau of the Census, PPL-47. [http://www.census.gov/population/www/projections/ppl47.html#hl-raceRace and Hispanic Origin Distribution\[1\]](http://www.census.gov/population/www/projections/ppl47.html#hl-raceRace and Hispanic Origin Distribution[1])
29. *States Ranked by Population (Black, Hispanic, White, Asian/Pacific Islander, American Indian) in 1998*. Population Estimates Program, Populations Division, U.S. Census Bureau. <http://www.census.gov/population/estimates/state/rank/strnktb2.txt>.

30. *New York's Populations Projections: 1995 to 2025*. State Populations Ranking Summary, Populations Division, U.S. Census Bureau.  
<http://www.census.gov/population/projections/state/9525rank/nyprsrel.txt>.
31. *Projections of the Total Populations of States: 1995 to 2025*. Populations Projections Program, Populations Division, U.S. Census Bureau.  
<http://www.census.gov/population/projections/state/stpjpop.txt>.  
*Projected State Populations, by Sex, Race, and Hispanic Origin: 1995-2025*. Series A projections. Populations Projections Program, Populations Division, U.S. Census Bureau.  
<http://www.census.gov/population/projections/state/stpjrace.txt>.
32. *New York's Populations Projections: 1995 to 2025*. State Populations Ranking Summary, Populations Division, U.S. Census Bureau.  
<http://www.census.gov/population/projections/state/9525rank/nyprsrel.txt>.
33. Hertman, C, and Keating, DP (eds). *Developmental Health and the Wealth of Nations: Social, Biological, and Educational Dynamics*. 1999. p. 6.
34. *Poverty 1998 Graphs: Number of Poor and Poverty Rate 1959-1998*. U.S. Census Bureau.  
<http://www.census.gov/hhes/poverty/poverty98/pov98.html>.
35. *Poverty 1997 Graphs: Proportion of People Below Poverty by Race: 1997*. U.S. Census Bureau. <http://www.census.gov/hhes/poverty/poverty97/povrac97.html>.
36. *Asians and Pacific Islanders Have the Nation's Highest Median Household Income in 1997*, *Census Bureau Reports*. Economic and Statistics Administration, U.S. Census Bureau. CB 98-177. September 24, 1998.
37. Centers for Disease Control and Prevention HIV/AIDS Surveillance Report: U.S. HIV/AIDS cases reported through June 1999. 11:1, p. 3.
38. *Need for Sustained HIV Prevention for Gay and Bisexual Men: HIV Infections Continue at High Levels Among Men of All Races with Dramatic Impact Among Men of Color*. Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention, Divisions of HIV/AIDS Prevention. January 2000.
39. Centers for Disease Control and Prevention HIV/AIDS Surveillance Report: U.S. HIV/AIDS cases reported through June 1999. 11:1. p. 14-15.  
 Centers for Disease Control and Prevention HIV/AIDS Surveillance Report: U.S. HIV/AIDS cases reported through June 1994 6:1. p. 13.
40. *HIV/AIDS Among US Women: Minority and Young Women at Continuing Risk*. Centers for Disease Control and Prevention. National Center for HIV, STD, and TB Prevention, Divisions of HIV/AIDS Prevention. August 1999.
41. Centers for Disease Control and Prevention HIV/AIDS Surveillance Report: U.S. HIV/AIDS cases reported through June 1999. 11:1. p. 14.
42. New York State AIDS Surveillance Report data as of September 30, 1999.

43. Centers for Disease Control and Prevention HIV/AIDS Surveillance Report: U.S. HIV/AIDS cases reported through June 1999. 11:1. p. 14-15.
44. New York State AIDS Surveillance Report data as of September 30, 1999. Table 1, 4A, 6D, and 7.
45. New York State AIDS Surveillance Report data as of September 30, 1999. Table 1, 4A, 6D, and 7.
46. *HIV/AIDS Among US Women: Minority and Young Women at Continuing Risk*. Centers for Disease Control and Prevention. National Center for HIV, STD, and TB Prevention, Divisions of HIV/AIDS Prevention. August 1999.
47. Centers for Disease Control and Prevention HIV/AIDS Surveillance Report: U.S. HIV/AIDS cases reported through June 1999. 11:1. p. 16-21.
48. Centers for Disease Control and Prevention HIV/AIDS Surveillance Report: U.S. HIV/AIDS cases reported through June 1999. 11:1. p. 16-19. 22-23.
49. Centers for Disease Control and Prevention HIV/AIDS Surveillance Report; U.S. HIV/AIDS cases reported through June 1999. 11:1.p.20-23.
50. Centers for Disease Control and Prevention HIV/AIDS Surveillance Report: U.S. HIV/AIDS cases reported through June 1999. 11:1. p. 15.  
*Young People at Risk: HIV/AIDS Among America's Youth*. Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention, Divisions of HIV/AIDS Prevention. August 1999.
51. *Young People at Risk: HIV/AIDS Among America's Youth*. Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention, Divisions of HIV/AIDS Prevention. August 1999.
52. *Drug-Associated HIV Transmission Continues in the United States*. Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention, Divisions of HIV/AIDS Prevention. August 1999.
53. Centers for Disease Control and Prevention HIV/AIDS Surveillance Report: U.S. HIV/AIDS cases reported through June 1999. 11:1. p. 16-19. 22-23.
54. Centers for Disease Control and Prevention HIV/AIDS Surveillance Report; U.S. HIV/AIDS cases reported through June 1999. 11:1.p.20-23.
55. Presentation to the New York State AIDS Advisory Council by New York State Department of Health AIDS Institute staff. November 4, 1999.
56. Presentation to the New York State AIDS Advisory Council by New York State Department of Health AIDS Institute staff. November 4, 1999.
57. *Population Estimates for States by Race and Hispanic Origin: July 1, 1998*. Population Estimates Program, Population Division, U.S. Census Bureau.  
<http://www.census.gov/population/estimates/state/srh/srhus98.txt>

58. New York State AIDS Surveillance Report data as of September 30, 1999. Table 4A.
59. New York State AIDS Surveillance Report data as of September 30, 1999. Table 6D.
60. Centers for Disease Control and Prevention HIV/AIDS Surveillance Report: U.S. HIV/AIDS cases reported through June 1999. 11:1, p. 3.
61. Centers for Disease Control and Prevention HIV/AIDS Surveillance Report: U.S. HIV/AIDS cases reported through June 1999. 11:1. p.35.
62. Presentation to the New York State AIDS Advisory Council by New York State Department of Health AIDS Institute staff. November 4, 1999.
63. New York State AIDS Surveillance Report data as of September 30, 1999. Table 6A, 6D, and 8.
64. *Drug-Associated HIV Transmission Continues in the United States*. Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention, Divisions of HIV/AIDS Prevention. August 1999.
65. *Need for Sustained HIV Prevention for Gay and Bisexual Men: HIV Infections Continue at High Levels Among Men of All Races with Dramatic Impact Among Men of Color*. Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention, Divisions of HIV/AIDS Prevention. January 2000.
66. *Sexual Health Survey: Sexual Health and Practices of Gay, Bisexual, and Homosexually Active Men in New York City*. Gay Men's Health Crisis. June 1999. p. 7.
67. *HIV/AIDS Among Hispanics in the United States*. Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention, Divisions of HIV/AIDS Prevention. August 1999.
68. Centers for Disease Control and Prevention HIV/AIDS Surveillance Report: U.S. HIV/AIDS cases reported through June 1999. 11:1. p.12.
69. New York State AIDS Surveillance Report data as of September 30, 1999. Table 4A.  
Centers for Disease Control and Prevention HIV/AIDS Surveillance Report: U.S. HIV/AIDS cases reported through June 1999. 11:1. p. 14-18.  
*HIV/AIDS Among African Americans*. Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention, Divisions of HIV/AIDS Prevention. August 1999.  
*HIV/AIDS Among Hispanics in the United States*. Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention, Divisions of HIV/AIDS Prevention. August 1999.
70. New York State AIDS Surveillance Report data as of September 30, 1999. Table 4A.
71. New York State AIDS Surveillance Report data as of September 30, 1999. Table 1, 4B, and 7.  
Centers for Disease Control and Prevention HIV/AIDS Surveillance Report: U.S. HIV/AIDS cases reported through June 1999. 11:1. p.8-9.

72. Chiasson, MA. Presentation to the New York State AIDS Advisory Council. New York City Department of Health. November 3, 1999.  
Forlenza, S. Presentation to the New York State AIDS Advisory Council. New York City Department of Health. November 3, 1999.
73. *About the AIDS Institute 1999*. New York State Department of Health. 1999.
74. Presentation to the New York State AIDS Advisory Council by New York State Department of Health AIDS Institute staff, November 4, 1998.
75. *Distribution of AIDS Institute Contractors by Zip Code and 1999 Community Need Index Scores*. Information Systems Office AIDS Institute, New York State Department of Health. October 1999.
76. Presentation to the New York State AIDS Advisory Council by New York State Department of Health AIDS Institute staff, November 4, 1998.
77. *New York State AIDS Drug Assistance Program Enrollment by Year by Race/Ethnicity*. New York State Department of Health AIDS Drug Assistance Program. September 30, 1999.
78. *New York State AIDS Drug Assistance Program Combination Antiretroviral Utilization by Race/Ethnicity (Three+ARV)*. New York State Department of Health AIDS Drug Assistance Program. September 30, 1999.
79. Hansell, D. Presentation to the New York State AIDS Advisory Council, December 9, 1998.
80. Verdino, J. Presentation to the New York State AIDS Advisory Council, December 9, 1998.
81. Egan, J, and Mesh, B. Presentation to the New York State AIDS Advisory Council, December 9, 1998.
82. *HIV/AIDS Among African Americans*. Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention, Divisions of HIV/AIDS Prevention. August 1999.  
*HIV/AIDS Among Hispanics in the United States*. Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention, Divisions of HIV/AIDS Prevention. August 1999.
83. *Drug Associated HIV Transmission Continues in the United States*. Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention, Divisions of HIV/AIDS Prevention. August 1999.
84. *Need for Sustained HIV Prevention for Gay and Bisexual Men: HIV Infections Continue at High Levels Among Men of All Races with Dramatic Impact Among Men of Color*. Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention, Divisions of HIV/AIDS Prevention. January 2000.
85. *HIV/AIDS Among US Women: Minority and Young Women at Continuing Risk*. Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention, Divisions of HIV/AIDS Prevention. August 1999.



86. *Young People at Risk: HIV/AIDS Among America's Youth*. Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention, Divisions of HIV/AIDS Prevention. August 1999.



# APPENDIX I

## New York State AIDS Advisory Council Communities of Color Presentations

### Excerpted from Council minutes

---

AAC meeting- 5/99

#### **HIV/AIDS in Communities of Color**

Invited speakers: **Yvonne Graham, Caribbean Women's Health Association; David Chen, Chinese-American Planning Council; Monique Wright-Williams, Syracuse Model Neighborhood Facility; Henry Crevecoeur, M.D., Brownsville Multi-Service Family Health Center; and Julia Andino, AIDS-Related Community Services.**

Ms. **Yvonne Graham** began by noting that the Caribbean Women's Health Association (CWAHA), established in 1982, serves a diverse population of men, women, and children. The prime populations are immigrants from the Caribbean and Central and South America, although client families come from all over the world. Services are principally provided in north central Brooklyn, Far Rockaway, and southeast Queens. A multilingual staff of 47 provide the following services: maternal/child health (community health worker perinatal case management); WIC nutrition; women's wellness; abstinence education; asthma outreach and education; domestic violence; immigration; and HIV/AIDS including adolescent services, case management, and peer education. With Lutheran Medical Center and the Sunset Park Family Health Center network, CWAHA operates the Caribbean American Family Health Center in East Flatbush, Brooklyn.

The organization has increased HIV/AIDS awareness, promoted testing and counseling, provided direct services to more than 100,000 people, strengthened community infrastructure, and collaborated with other organizations to facilitate conferences and research. Barriers to service for targeted populations are similar to those for others: access, cultural competency, racial and ethnic health disparities, and insufficient resources. For immigrants, language barriers, service utilization, cultural traditions, and immigration issues are also important factors.

Ms. Graham listed specific problems: newly arrived immigrants have varying levels of knowledge about HIV. They may be reluctant to legalize guardianship and permanency planning arrangements for children out of fear of violating family trust. Under new immigration policies, use of federal means-tested programs, such as Medicaid, WIC, child health insurance, TANF, food stamps, and housing, can jeopardize immigration status for recent permanent residents or those petitioning for alien resident status. Immigrants may, therefore, avoid the use of health care. Immigrants married to U.S. citizens and applying for residency may not be approved if HIV-positive, unless they apply for a health waiver, which requires proof of the means to pay for their own health care. If they cannot afford health care insurance, they remain untreated, undocumented and face deportation. Undocumented people live in constant fear and have negligible benefits.

CWHA recommends: 1) continued investment in communities through long term partnerships with organizations; 2) ongoing support for education about HIV prevention, permanency planning, guardianship, and access to health care; 3) state funding for legal immigrants during their five-year wait for permanent resident status when they cannot use federal means-tested programs and for permanent residents who intend to sponsor relatives and face immigration consequences if they use federal programs; 4) encouragement for managed care organizations to make social investments in the communities in which they operate; and 5) technical assistance to community organizations for capacity building, data collection and analysis, and management information systems technology.

**Mr. Chen** is Executive Director of the Chinese American Planning Council (CPC), a multi-service agency in New York City that primarily serves new immigrants. Established in 1965, the agency facilitates access to services and development of skills to encourage self-sufficiency and integration into the community. Programs include child care, child and family services, after-school youth programs, job training and placement services, home care, and the development and management of low income housing for the elderly. Although CPC is not a health agency, it incorporated HIV/AIDS services in 1990. Then and now there was and is great ignorance of HIV. People believed it could be transmitted at swimming pools, restaurants, and from toilets. The early Chinese translation of AIDS was "love to die." People thought it was a disease that only affected other communities.

Many HIV issues in the Chinese-American community are similar to those of other groups. There are cultural, linguistic, economic, legal, and institutional barriers. Many people of Asian cultures avoid discussing sexual behavior, illness, and death. Women are often marginalized in HIV prevention, facing barriers in the home, clinic, and workplace. The rise of the sex industry puts many people in danger, and in this occupation economic need is often a higher priority than disease prevention. Immigration rules prevent many people from seeking permanent residency status and government services, such as HIV testing. Immigrants are often isolated and unfamiliar with the public health system. For many, the key issue is fear. Police, sex work, immigration status, family planning, and language barriers must all be addressed. Additional problems include misconceptions about HIV and about the community.

HIV-related services provided by CPC include advocacy, community outreach, prevention education, networking, case management, and client support services in Manhattan, Brooklyn, and Queens. CPC collaborates in the use of mobile vans for a range of health screenings, including HIV counseling and testing. They have developed a series of videos in Cantonese and Mandarin to address different groups and are developing facilitator guidelines for group discussion. Workshops and conferences are organized for providers, pharmacists, hospital social workers, church workers, and others. Although the proportion of Asians and Pacific Islanders (API) with HIV is low, about 1% nationally and less in New York City, the rate doubled between 1983 and 1990 and has doubled again. It will be over 4% by 2020. Lack of reporting and surveillance data obscure the true extent of the problem.

There are also cultural differences within API communities, and most are underserved in terms of health services in general. There is a great lack of translated materials. Globally, by 2000, the highest number of AIDS cases will be in Asia. Given projected migration patterns, HIV

prevention will become even more important. Needs assessment, greater resources, and community involvement in program design are necessary. Lack of access, ignorance, and denial should also be seen as risk factors.

**Ms. Wright-Williams** is Director of the FACES program (Fighting AIDS/HIV through Case Management, Education, and Support). Begun in 1994 as part of a multi-service agency, FACES provides services to the African American, Latino, and Southeast Asian populations of Syracuse. It was formed despite other social and AIDS service programs in the area because of a lack of appropriate HIV services for people of color and because the intersection of race and health care is so complicated. It is often easier to integrate AIDS services into a culturally appropriate atmosphere than to develop cultural competency in existing AIDS service programs. Grafting a program for persons of color onto an AIDS-specific organization is like creating an interracial union, accepted by some, severely rejected by others. While anyone can provide services to people of color, they are best provided by people of color.

When people ask what is needed, they must be willing to listen and hear the expressed needs and respond in a positive and supportive manner. They must be willing to trust that assessments will be accurate and preconceptions may not be valid. One issue in upstate New York is an absence of materials and services designed for lesbians of color. Some available materials are too sexually explicit. In addition, greater and more intensive contact with adolescents is essential. Interventions must address the entire adolescent, not just sexual practices. How can programs persuade teenagers to protect themselves from AIDS when some youth do not imagine living long enough to die of AIDS-related illnesses? Language is also becoming more of a problem with a growing number of Latino and Asian clients. Often bilingual or bicultural staff are not available.

Emerging problems include the following: 1) Requirements for interagency collaboration with shared resources that are barely adequate for a single agency's work. This leads to high staff turnover or burnout and disappointing agency performance, which affects future grants; 2) The paucity of people of color in funding agencies, making communication about sensitive issues difficult. The misspelling of Latino words, for example, leads people to doubt whether others care about Latino issues or people; 3) Constraints of partner notification laws. When someone with HIV cannot be convinced to protect or notify her partners and the agency is prevented from acting by confidentiality laws, the message heard is that people of color are expendable.

The challenge for funders is to create an atmosphere and a level of inclusion of people of color in decision making processes that mirror the requirements and suggestions for representation of people of color in funded agencies.

**Dr. Crevecoeur**, from Brownsville Multi-Service Family Health Center in Brooklyn, noted that he is originally from Haiti. It is very rewarding to see the great improvement in quality of life that new medications have allowed for people with HIV in his neighborhood, although people in Haiti do not have access to these treatments.

More than 31% of people in East New York and Brownsville need some type of public assistance. Regarding ADAP limitations, the \$44,000 cap for eligibility does not affect most, but

does affect some patients, whose jobs cannot provide adequate health insurance coverage. He also noted that while drugs have had strongly beneficial effects, they can also cause problems for some patients, precipitating diabetes and cholesterol and lipid abnormalities. ADAP has recently begun to pay for medications for these disorders.

“Poly-clinic” situations, in which patients attend several clinics, and “poly-pharmacy,” in which they accumulate and take multiple prescriptions, are common problems. Without coordination, drugs can have dangerous interactions. The complexity of HIV medications in particular requires careful management. If patients come in contact with physicians who are not well trained in HIV, quality of care can be compromised. Patients also sometimes demand inappropriate medications. He described an incident in which a patient became violent when drugs were refused.

Patients who recover from very serious illness sometimes exhibit a “Lazarus syndrome,” that is, once the immediate fear of death recedes, other mental and behavioral problems emerge. These may include depression and anxiety about a lack of skills to obtain a job and inability to plan how they will spend their time.

**Ms. Andino** is Assistant Director for Client Services for the Mid-Hudson Region for AIDS-Related Community Services (ARCS), the third largest AIDS service provider in New York State. Counties served by ARCS include Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, and Westchester. This geographic diversity is itself a challenge. The agency’s mission is to allay fear, reduce HIV transmission, and ensure access, equity, and justice for people with HIV. The agency offers case management, HIV counseling and testing, community education, street outreach, referrals, harm reduction, food pantries and other supportive services such as transportation. HIV counseling and testing has increased in recent months, mostly for young people, women, Latinos, and African Americans. There have been over 100 support group sessions with about 250 participants and more than 3,000 participants in prison education events. The 70 staff members serve a total of about 25,000 people in all activities.

In the Hudson Valley area, the rate of HIV infection continues to rise among women, racial and ethnic groups, and youth. In Dutchess County alone, last year there was a 50% increase in HIV infection. Injecting drug use (IDU) is the primary mode of transmission. It is a challenge to engage people in rural communities, such as Sullivan County, for counseling and testing. There has been a substantial increase in infection among people of color over the past five years in several counties.

Service gaps include a lack of culturally and linguistically appropriate programs for growing numbers of seasonal and migrant workers and immigrants. Other problems are geographic isolation of many communities; lack of access to medical care; need for Spanish-speaking primary care providers and prevention and treatment education materials in Spanish; lack of provider knowledge about immigration issues; lack of HIV, recreational, and support programs for youth; need for assistance with back to work issues such as child care, housing, and vocational rehabilitation; and lack of information about parental rights upon incarceration.

The agency recommends the following: 1) increase funding for community service providers as caseloads have increased by 36% in the last 5 years; 2) build coalitions with indigenous groups

to increase outreach and education in isolated areas; 3) implement small drop-in centers in rural counties for information and services; 4) provide ongoing training in cultural sensitivity for staff, who should reflect the communities served; 5) provide more agency educators for inmates and expand inmate peer education; 6) increase funding for HIV/AIDS treatment education and adherence programs; 7) increase family-based programs and coordination between the child welfare and criminal justice systems.

#### **AAC meeting - 6/99**

#### **HIV/AIDS in Communities of Color — Presentations on Policy Issues**

**Darrell Wheeler, Ph.D., Columbia University; Mildred Pinott, Esq., Legal Aid Society; Leo Rennie, Harlem Directors Group; Michael Ezie, Blue Cross/Blue Shield of Western New York; Cissy Elm, American Indian Community House; Pernessa Seele, Balm in Gilead; Debra Fraser-Howze, Black Leadership Commission on AIDS.**

**Dr. Wheeler**, Columbia University School of Social Work, is a behavioral scientist who works part time with the AIDS Institute's Division of Prevention and the New York State HIV Prevention Planning Group (PPG). He noted that his presentation could be titled "Research to Street Search: Integrating Practice and Research." There is increasing emphasis on how research and theory guide practice. Research helps identify service gaps and issues related to resource allocation, accountability, outcome, and quality of care. However, research and evaluation do not occur in a vacuum and should not become ends in themselves. Buzz words like "cultural," "ethnic," and "racial diversity" are only words. It's not clear how they relate to research, practice, prevention, and intervention. What actually is a "non-racial" or "non-ethnic" community? Race and ethnicity must be recognized, but in context with other issues such as history and economics. It's a difficult task to understand how to do advocacy in relation to research and evaluation for a broad spectrum of constituents.

There is an intense need to translate, rather than just impose, language. It must not be just a top-down approach. It is only through an active process of translating information in collaboration with community people that effective work can be done. During a recent PPG meeting, a half-day exercise attempted to identify barriers and ways of facilitating work. Providers have conceptual models, but these are not always the ones widely promoted. Greater infrastructure and markers for efficacy must be developed. Data collection should be both quantitative and qualitative. This must be an ongoing effort. Intervention, prevention, research, and evaluation must be inclusive of many contributors.

**Ms. Pinott**, a supervising attorney at the Legal Aid Society's Community Law Office in East Harlem, works in community and hospital-based programs that assist parents in making future care and custody arrangements for children. Funded initially by the AI and now also receiving Ryan White Title I funds to offer legal services to single, childless people and people with parole revocations, multidisciplinary teams from the Community Law Office send members to work with hospital and community organization staff. The Office is also a community coordinating agency under subcontract with the Harlem Directors Group.

The term "permanency planning" is often associated with the child protective system and does not engender trust. Future care and custody, by contrast, recognizes that there is nothing necessarily permanent about the arrangements that some parents wish to make. There must be recognition and respect for the fluidity of this process, rather than pushing or scaring people into making permanent decisions. While many patients are doing well now, many others are not, or do well until they suddenly become very sick. They often do not want to make these very difficult decisions when they are well. Yet providers expect people with HIV to come in, sit down, identify their resource person, document it, and go to court to make sure the plan takes effect. What about the changing dynamics of familial situations and children's needs at different ages? Providers and funders must understand that future care and custody is an ongoing process. Sometimes it's crisis intervention done at the bedside. Wherever it's done, it is still very much a serious, widespread problem, contrary to the perception that it's no longer a priority.

Prevention and intervention must have a unified approach that does not alienate people. Women often access legal services in abuse/neglect scenarios, in which the use of euphemistic language does nothing to protect HIV confidentiality. Often HIV medical and mental health problems are complicated by substance abuse. The Adoption and Safe Families Act of 1997 has moved the focus away from family reunification and toward child safety and an expedited process for termination of parental rights. Preventive services are key. They must be in place in the most affected communities. As an attorney, Ms. Pinott often must do social work, coordinate services, and accompany clients to find medical services.

Mr. Rennie noted that his organization, the Harlem Directors Group, is a consortium of service providers based in upper Manhattan that serves as the community service program (CSP) for that region, including the provision of capacity-building and technical assistance to African American and Latino organizations. Policy work is funded through a private foundation. The agency's treatment education program is Project Teach.

Focusing on policy, Mr. Rennie addressed questions about 1) emerging issues and 2) strategies to inform key decision makers about the disproportionate impact of HIV/AIDS on communities of color and help them to develop sound policy and funding allocations. Questioning whether the term "communities of color" is really appropriate, he noted the different groups artificially gathered under this heading: African American, Latino/Hispanic, Asian/Pacific Islander, and Native American. Each racial/ethnic group (and their many sub-populations) has unique and complex issues. Lumping them together generates inappropriate policy and resource planning and obscures the distinct issues. For example, every group mentions the need for cultural competency, but only Latinos consistently define this issue as one of language translation. Native Americans and the API communities have data collection issues and the problem of demonstrating the relative epidemiological importance of HIV in their groups and planning for prospective need.

African American and Latino issues are essentially those the entire AIDS community has been facing for years: HIV surveillance, treatment advances and combination therapies, uncertain funding streams, managed care, health care delivery focused on cost control, and the federal debate about AIDS exceptionalism. However, the question is how these issues affect care on a local level in African American and Latino communities. About 80% of cumulative AIDS cases



are among African Americans and Latinos. This is not a new development, but suddenly it's in the foreground.

What will the responses be? There is a great need for integrated systems of prevention and treatment for poor and underserved populations in general. Early identification and counseling and testing are important, but cannot be the only services. People who test positive must be linked to care. People who test negative must have ongoing preventive services. HIV/AIDS can no longer be considered in a vacuum. Many communities have high rates of poverty, mental illness, STDs, violence, and substance use, in addition to HIV. These conditions have perhaps fostered high rates of HIV and perhaps also account for the slow response to HIV in African American communities. HIV was seen as a gay white male disease when there were many other problems to solve. But at this point, we must think about how to connect AIDS with a larger health agenda. Declaration of a state of emergency for HIV and attention of the Congressional Black Caucus to HIV will be very important, but we still must think broadly across many health areas.

Current hot issues include the rapidly increasing HIV rates. In New York State, while blacks consist of 15% of the population, they represent 47% of AIDS cases reported in 1997. Treatment advances offer hope but are not necessarily accessible to all who need them. There has been a lot of talk about the decline in AIDS deaths, but African Americans did not benefit as much as whites, probably because of the other socioeconomic problems that affect health outcomes. The connections between HIV and substance use must receive much greater attention. Besides funding for syringe exchange, discussion of the role of non-injecting drug use should take place. Crack use, for example, places women at higher risk for HIV infection. Regarding resources, at this time when AIDS is out of control in many communities, state funding has not increased. Criminal justice issues are very important and should include those for parolees. From New York City data, it can be estimated that about 9% of all black males are HIV positive at entry into the prison system. Discharge planning is essential if returning inmates are not to infect their partners.

To inform policy makers, collaboration and data exchange is essential with groups such as the PPG, Statewide AIDS Service Delivery Consortium (SASDC), and the AIDS Advisory Council. The state could make data and information more accessible. For example, if we have to have HIV reporting, perhaps this data could be made available to communities and organizations for planning. Real partnerships must be implemented. The Harlem Directors Group demonstration project in capacity-building was successful because the language about partnerships was taken very seriously. The AI could capitalize on the energy generated by creation of a state of emergency by helping to further develop leadership in African American, Latino, and other communities. Finally, given that early in the epidemic African Americans and Latinos were not well served, at this point direction should come from those communities.

**Mr. Ezie** reported that African Americans are more than 8 times as likely as whites to have HIV/AIDS and Hispanics more than 4 times. In October 1998, the federal announcement of the \$156 million initiative to combat HIV/AIDS in minority communities, gave recognition to its seriousness. CDC data from 25 states show that African Americans account for 57% of new infections, although they comprise only 13% of the U.S. population.

In New York, the recently enacted HIV Reporting and Partner Notification Act is not seen as likely to encourage voluntary counseling and testing. There is an intrinsic and well founded lack of trust in government systems among minorities, so that disclosure of personal health information is perceived to be risky despite assurances of confidentiality. There is also traditional disaffection for legal authorities, so that immigrants may be particularly reluctant to seek testing. With New York City a port of entry for so many immigrants, this should be of great concern to policy makers.

In 1997, AIDS was the primary cause of death for African Americans between the ages of 25 and 44. More than 60% of deaths were injection drug use related. For Latinos, AIDS was the second leading cause of death for the 25 to 44 age group, with more than 50% drug related. Harm reduction programs have proven effective in reducing the spread of AIDS through injection drug use. Several legislators have introduced bills to support needle exchange programs and syringe deregulation, which is an important issue that should be promoted.

Key decision makers should have access to data and information about these issues. SASDC, the AIDS Institute, and the AIDS Advisory Council have large stores of information. Wider distribution of newsletters from networks and community organizations would be helpful in bringing issues to the attention of policy makers. The incident in Chautauqua last year (in which 31% of the 42 identified primary sexual contacts of an HIV-positive man became infected) revealed that large numbers of young people are at high risk for HIV and STDs even in rural communities. All young people should have the knowledge, skills, and social support necessary to protect themselves from infection. Better prevention activities may have reduced the number of people who engaged in unprotected sex, and might have been implemented if officials had had more information and data.

Sharing information has, in fact, improved prevention. In Buffalo, which had some of the highest teenage pregnancy rates in the State, community workers and activists determined that pregnancy prevention information had to be dispensed in schools. Although it was a long fight, changes in the school curriculum finally allowed age-appropriate sex education. After only three years of this policy, data show the first decline in teen pregnancy rates after many years of increases.

In many communities of color, although the church is a strong institution, it has not led in the fight against AIDS. Many churches are now changing after reviewing the data. Much more education is needed. Although fewer people are dying of AIDS, there is a lot to be done to insure that fewer persons are infected and that vulnerable people and groups are protected.

**Ms. Elm**, Director of the HIV/AIDS Project, a prevention and advocacy program of the American Indian Community House, reported that the Project has five sites statewide: in the nation; Manhattan; Riverhead, Long Island; Buffalo; and Syracuse.

Ms. Elm is a member of the Onondaga Nation in central New York, a traditional body of the Haudenosaunee. She noted that it's not talk about cultural sensitivity that's important, but actions. A history of genocide, land claims, and many forms of discrimination have made Native Americans justifiably suspicious of anything government-related. However, the AIDS Institute has been successful in working with Native American people. Because of sovereignty issues,

some nations do not receive federal funds directly and therefore have access only to state block grants. At one point, there was less than \$1 million for Native American health care at all clinics statewide. The Onondaga Nation got \$450,000 of this for the year to care for 3,000 people.

Although Native Americans comprise only 1% of the total population, they have higher rates of HIV infection which will soon translate into disproportionate cases of AIDS. This is clearly a crisis situation. Initially, AIDS was seen as a gay white male disease and therefore not of concern to Native Americans. However, the epidemic and the understanding of it have changed. Heterosexual contact, work in cities, and exposure through the influx of non-native peoples coming to casinos in the nations have increased the risk of HIV.

Native Americans must be involved in meetings and groups and policy discussions. It's difficult to take seriously an interest in cultural sensitivity if Native Americans are not even represented at the table. Although there are only a few Native American activists in the State working on this issue, they should be contacted. The AIDS Institute and other organizations must help them to help their communities, especially in reducing the mistrust that impedes prevention work. While the Project is not funded for health care, more and more HIV-positive people are coming to the sites looking for health care.

Ms. Seele reported that the organization has been working with African American churches on HIV/AIDS issues for the past 10 years, beginning in Harlem, discussing sex, condoms, homosexuality, homophobia, and other issues in the context of religion. This context is the key to success in working in all communities of color. In black communities, the church IS the community. It includes gay people, drug addicts, sexually active and inactive people, seniors, professionals, people living with AIDS, and many others.

Ms. Seele compared the \$500,000 annual budget for the Office of Minority Health with the \$1 million cost of one bomb dropped on Kosovo. The problem of HIV/AIDS in African American communities was known and predicted 10 years ago by the CDC. Yet at that time, nothing was done because no one cared about minority communities. If efforts had been taken then, the situation might have been different. Now, the various communities of color are required to compete with each other and with gay white groups for the insufficient funding available. There would be enough money for every community if there were enough concern. There is no one community of color; each should be considered separately.

The religious community and its social structures set the norms for addressing HIV. Lives are dependent on spiritual support, and it is therefore critical that focus be placed on the religious community. Many churches and mosques are becoming very involved in HIV/AIDS services, expanding their basements for HIV testing, developing AIDS ministeries (programs), and distributing condoms. Religious representatives should be part of all groups designing policy and programs.

AIDS education remains outside the marketplace, where sex and violence rule. There is no AIDS education in advertising. Behavior has been changed about smoking and drunk driving, but no aggressive tactics have been used for AIDS prevention. If anyone can watch sex on television standing in Times Square, they should also be able to learn about AIDS prevention in Times

Square, including condom billboards, abstinence messages, and HIV treatment information. We need effective, appropriate leadership.

**Ms. Fraser-Howze** noted that she wanted to focus on an action plan. African Americans have a higher rate of death from all chronic diseases than any other population, including all other minority communities combined. This was a public health problem even before HIV/AIDS. Blacks now account for more than 56% of new HIV infections in the nation, and nearly 70% in New York State. There is no question that, even more than at the federal level, in New York this is a state of emergency.

Ms. Fraser-Howze requested that the AIDS Advisory Council meet with the Black and Latino Caucus of the Assembly and ask for a declaration of a state of emergency regarding AIDS and public health in African American and Latino communities. She said that this is not a political issue. The epidemic is becoming multi-generational. The numbers are comparable to those in third world countries. Every hour in the U.S. seven people are newly infected with HIV and three are African American. That hasn't been on the front page of the newspapers. There is no community more affected than African Americans. AIDS has propelled African Americans into the most serious health crisis ever faced by any group in the U.S. in modern times. It is unacceptable to meet and exchange statistics and then leave without an action plan.

Ms. Fraser-Howze distributed a combined series of articles reprinted from Newsday, November 29 to December 7, 1998, titled "The Health Divide," documenting health disparities between blacks and whites for many diseases. Health care represents about 39% of the gross national product. Doctors cannot abdicate their rightful responsibilities as public health advocates.

She said that at this point there should at least be a public meeting at which the Governor is given a memorandum with the statistics about HIV/AIDS in African American and Latino communities, making the point that this is an ongoing severe crisis. The Council should then bring its position to the New York State legislative Black and Latino Caucus. The first discussions about developing education and advocacy skills among leaders in African American communities were dismissed. But this eventually led to \$156 million from the federal government. Now the information and momentum must come from the State as well.

Declaration of a state of emergency would allow the deployment of emergency support teams and medical personnel to do analysis and data collection. It would allow review of the allocation of existing resources and help to channel new ones appropriately where the public health emergency is. It would target both urban and rural communities. It would require review of other public health indicators that have an impact on rates of death from chronic disease. It would facilitate integrating HIV/AIDS into other public health activities, which would presumably help to expand the Office of Minority Health (\$500,000 is not acceptable and precludes credibility). It would lead to extensive governmental analysis of state funding around all areas of disease prevention and health promotion. It should provide for additional funding for comprehensive drug treatment and future care for children. An unprecedented advocacy fight is necessary to protect children. It would establish initiatives to address racial health disparities, integrating behavior research models into prevention.

Declaring a state of emergency would also help to fund appropriate evaluations using start and end point analyses: Previous end point only analysis resulted in substantial cuts to direct funding of minority organizations. However, if organizations are in fact not working, they should not be funded. A state of emergency will allow for building the kind of cultural competency that is required. These culturally respectful changes will have to be integrated into everything that is done and every decision made. An example of ignoring large segments of the population was illustrated by the result of changes in the CDC definition of AIDS to include conditions affecting only women. The inclusion of cervical cancer as an HIV-related condition increased reported female HIV infections by 193%. These women had been dying all along but no one was testing them for HIV.

There is a lot of work to be done at the community level. However, the State and the Council need to work with organizations to declare a state of emergency so that greater focus can result in appropriate resources, program development, and emergency interventions. If nothing is done, the black communities will simply be wiped out.

#### **AAC meeting - 7/99**

##### **Adolescent Issues — Provider Presentations**

**Joyce Hall, Greater Brownsville Youth Council, Inc.; Verna Eggleston, Hetrick Martin Institute; Dina Wilcox, New York State HIV Prevention Planning Group; Patricia Gogol, Capital Region BOCES/APPLE Program; and Rafael Mutis, Hispanic AIDS Forum.**

**Ms. Hall** noted that she has been Executive Director of the Greater Brownsville Youth Council for 11 years. Adolescent prevention services began in 1985, with funding for this from the New York City Department of Health beginning in 1988. The program uses peer education, improvisational theater, and outreach. Although the gap between numbers of male and female cases has narrowed, the risk factors for both genders remain sex with a male at risk and intravenous drug use. Brownsville is 85% black and 15% Hispanic; East New York is 65% black and 35% Hispanic. AIDS cases reflect this demographic division.

HIV prevention should really begin before adolescence. Information about sex and drug use must be understandable and culturally relevant. Peer educators, primarily black and Hispanic, receive 75 hours of training about HIV and sex and drug use risk factors and an additional 25 hours of communication skills training, including improvisational theater techniques and public speaking. Adolescent peer educators are paid as part time staff, working 20 hours a week. For the past five years, the program has also provided weekly education for incarcerated youth at Riker's Island.

In addition to HIV information, which is often not delivered in schools or ignored by students, youth must have interactive programs, such as improvisational theater, to build behavior change skills. There is a definite need for more adolescent peer education programs, intervention programs by community peers, HIV counseling and testing in adolescent-sensitive settings, and funding (the Brownsville program is still the only adolescent HIV prevention program in the area). HIV prevention should be integrated with other adolescent issues, many of which are seen as more important by youth. Adolescents need caring adults to provide information and guidance. She urged that the Advisory Council invite youth to speak at a Council meeting.

**Ms. Eggleston** confirmed that the approach to HIV prevention must be comprehensive and holistic. Hetrick Martin Institute serves 7,800 young people a year, 35% of whom are HIV-positive (probably an underestimate since adolescents do not seek services like adults), from 272 zip codes. About 46% are African American, 43% Latino, and 11% other. They list their sexual identities as gay, lesbian, bisexual, transgender, heterosexual, questioning, unknown, or "other."

Since hunger and poverty are the largest presenting issues, the Hetrick Martin Institute served 10,000 meals last year. Adolescents often exchange sex for food and shelter for themselves or their families. Many young people are the caregivers for their parents and many siblings. The \$5.25 an hour they earn as peer educators does not compare to the \$500 per night they might earn on the streets, and some parents will not encourage their children to stop prostituting themselves because the families have no other income. Families must often decide whether they will pay for health care or food.

The Hetrick Martin Institute is the oldest and one of the largest organizations serving gay adolescents in the country. Although many adolescents come because they don't want to go to programs in their own neighborhoods, it is still vital to have community programs staffed with people of color so that misinformation and cultural issues can be credibly addressed. A new development is sexual interaction between transgender (male to female) youth and male-identified lesbians, proving once again that young people will experiment and making it necessary to offer pregnancy prevention services for gay youth.

Information about risk reduction is not sufficient for adolescents. Since adolescents, regardless of background, are attracted to risk behavior, the Hetrick Martin Institute begins with risk perception. Lists of risk categories and profiling are useless and dangerous. Adolescents see themselves as outside of the identified risk categories and therefore not at risk. For example, many boys leave their own neighborhoods to have sex with males but do not identify as gay and return home to have sex with their girlfriends. Girls have unprotected anal intercourse to maintain their virginity. The message the Hetrick Martin Institute gives is that anyone who has had barrier-free sexual intercourse of any kind between 1969 and 1999 is at risk and should be tested.

Ms. Eggleston stressed that providers who talk to and work with young people must be willing to hear what they have to say, regardless of how it may conflict with the providers' values. Young people have sex and that fact must be recognized along with other uncomfortable facts. It is, for example, more socially acceptable and even economically advantageous to be pregnant than to be gay in many neighborhoods. Gangs are back. Providers must change their antiquated views and posters and questions to reflect the reality of many types of adolescent sexual behavior and identification. Adolescents have multiple simultaneous needs, and the Hetrick Martin Institute will, therefore, always have to be involved in all issues that affect them.

**Ms. Wilcox** reported that the New York State HIV Prevention Planning Group's (PPG) mandate is to determine the most effective type of prevention and to make those recommendations to the State. She has chaired the PPG Young People's Committee for nearly five years. The largest initial challenge was how to involve young people in discussions. The Committee went out to meet with adolescents in focus groups, holding sessions in Brooklyn, on the St. Regis-Mohawk reservation at the Canadian border, at Tupper Lake, in the Albany region, and elsewhere.

Thus far, feedback confirms that the message works best when it comes from peers. HIV is not necessarily the highest priority issue, and young people know what the priorities are in their areas. In Chautauqua, for example, long before the Nushawn Williams incidents, the major issue was the widespread desire for pregnancy among adolescent girls. Intensive attention to this might have had impact on many other problems including HIV infection rates. An example cited in Tupper Lake was the complete lack of privacy in small towns, preventing the purchase of condoms at the one pharmacy. A public health nurse has since initiated a program for anonymous access to condoms through the local pharmacy. At another focus group, young people requested that they not be called adolescents, but simply young people. Focus groups can help providers design programs to meet specific needs in individual communities; the needs of African Americans in rural areas, for example, are not the same as the needs of those in cities.

Ms. Wilcox attested to the potential value of inviting young people to speak at a Council meeting. This can illuminate the type of connection needed between the ways that young people define their lives and policy decisions. Young people have specific opinions about what they need.

**Ms. Gogol** runs the APPLE Program which trains teens as peer educators in Schenectady County. As a social worker, she has many perspectives on HIV prevention. The program uses interactive methods to promote learning and encourage personal understanding of HIV risk. However, access to communities of color is difficult. The state mandate for universal HIV education in schools is very weak. The largest inner city public school in the area does not allow any program that concerns sexuality, STDs, or HIV. The district wants control over all information taught. The APPLE Program tries to do outreach through community programs, churches, and youth groups, although young people do want information in school.

Although upstate youth have concerns common to those in New York City, beliefs among young people vary. Some upstate, for example, question what HIV is and whether it really exists. For some young people with families in denial the focus group was the only place they could talk about family members who had died of AIDS. Young people sometimes know more about HIV than adults and lead educational programs for parents.

It's not possible to establish uniform standard programs, Ms. Gogol said. Programs must be tailored to the developmental, geographical, and cultural needs of young people, and they must be provided at the community level. Other activities, such as an AIDS walk and the AIDS memorial quilt, can raise awareness in the general public.

**Mr. Mutis** is Coordinator of the Bronx Youth in Action Program of the Hispanic AIDS Forum, founded in 1985. The Youth Program provides peer education in the South Bronx and presentations throughout New York City. It requires a six-month internship, which includes discussion of race, economics, and access to information and health care. The program targets African American and Latino youth, ages 14-21.

Often there is no HIV education in the schools, and never more than a cursory AIDS 101 presentation, often without context or cultural appropriateness. There is a great need for places where young people can come to talk to each other and get information and condoms. Partnerships with schools and among providers must be developed. There is less current focus on

prevention, but still great need for discussion of real issues, such as racism, homophobia, self esteem, and differing perceptions of sexually active boys versus girls.

He stressed that young people deserve honest answers and respect for their ability to negotiate their lives. Further, HIV does not exist in a vacuum. HIV education has to do with community norms, not "targeting," which sees populations out of the context of their environments. Empowerment of individuals is only the beginning. Community norms that condone abusing children or battering women must be addressed. There is a long way to go to make HIV education culturally competent in matters of race, ethnicity, age, and gender.

### **AAC meeting - 12/99**

**Mr. Dennis DeLeon**, Executive Director, Latino Commission on AIDS, reviewed the epidemiology of HIV/AIDS in Latino communities and major issues combating AIDS in each population group.

Over ninety percent of the AIDS cases among Latinos in New York State occur in New York City and the surrounding counties. All groups share the risk of HIV infection through the direct or indirect effects of intravenous drug use. It is the major source of infection for men, women, their sexual partners, and their children. About seventy-five percent of mothers of HIV positive infants became infected through intravenous drug use. Intravenous drug use is responsible for more than a third of AIDS cases among people under 29.

Mr. DeLeon outlined recommendations to address HIV risk among intravenous drug users and other groups at high risk: young people, women, immigrants, inmates, and men who have sex with men. Regarding drug use, he endorsed increased funding for needle exchange programs and a public campaign to support them, decriminalization of needles and syringes, and expanded access to methadone and other drug treatment programs.

Sex with men is the primary source of infection for young Latino men, and drug use is the major risk for young Latinas. Recommendations for young people include frank education about safer sex to prevent HIV and other sexually transmitted diseases, easy access to HIV testing and condoms, specific outreach to immigrant youth, and the enlistment of family members, schools, and community resources in these initiatives.

New York State accounts for nearly forty percent of all U.S. AIDS cases in Latinas. The most critical problems for women are limited access to drug treatment, especially for pregnant women and those with children, high rates of HIV infection among incarcerated women, high risk sexual behavior despite knowledge of HIV risk, and the failure of HIV prevention education to effectively address women's lack of control of condom use and the barriers they face in discussing it with partners. HIV infection must be seen in the context of poverty, domestic abuse, lack of child care, sex work, and many other social and economic problems that define the lives of many women. Funding for HIV prevention programs should have a broader focus to reach more Latinas at risk.

Latinos account for 23% of inmates in New York State prisons but nearly 50% of those with AIDS. HIV infection rates of newly admitted Latino inmates are about 10% for men, 21%



for women, and about 30% to 40% for those who use drugs, rates well above those in other states. The Rockefeller Drug Laws of 1973, which provide harsh prison terms for the possession or sale of even small amounts of drugs and mandatory incarceration for repeat felons, are responsible for the vast majority of state prison sentences. The lack of bilingual staff and materials is the most important barrier to HIV prevention and treatment among Latino inmates. Discharge planning with HIV education for every inmate, in Spanish where appropriate, condom availability for inmates, and implementation of recommendations in the New York State AIDS Advisory Council's report on HIV in correctional facilities would greatly improve inmate health.

A large proportion of immigrants diagnosed with AIDS are from countries where Spanish is the primary language. Immigrants, especially the undocumented, typically live in impoverished areas, have low paying jobs, lack health insurance, are uninformed about services, and are reluctant to use health services because of language difficulties or fear of deportation. Thus, HIV infection may not be diagnosed. The most critical needs are for information and advocacy to help immigrants obtain legal status and needed services.

Among Latino men who have sex with men (MSM), HIV infection rates remain high and are increasing in younger age groups, despite decreased rates in gay white men. Nearly a third of Latino men who have sex with men also use injection drugs. Many men are bisexual. However, since in some Latino cultures male sexuality incorporates sex with men without ascribing labels, programs for gay men may not reach Latino bisexuals. More programs are needed that recognize Latino concepts of sexuality and health, especially for youth.



## APPENDIX II

### Direct Service Funding Administered by State DOH AIDS Institute

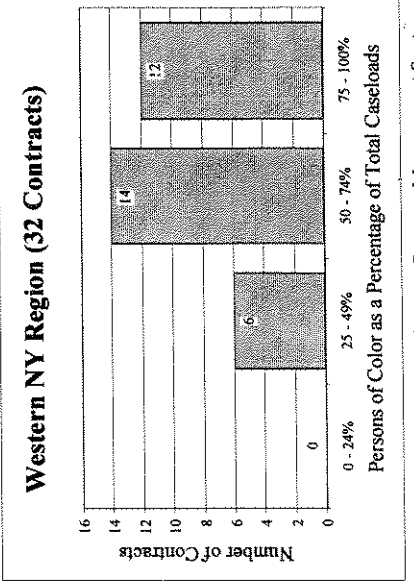
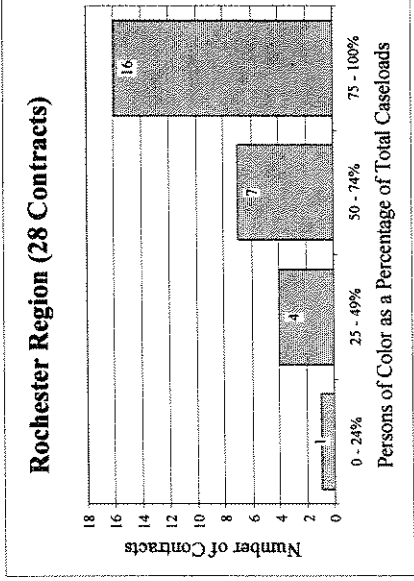
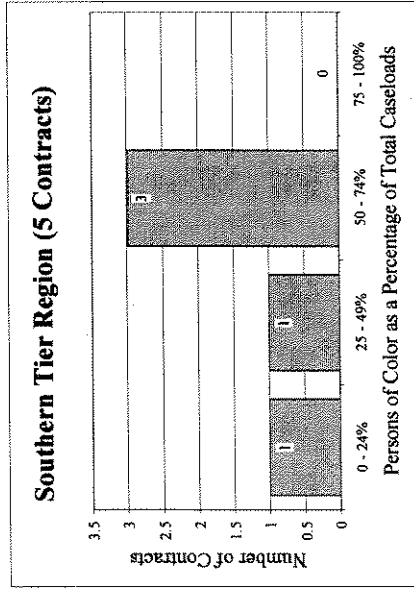
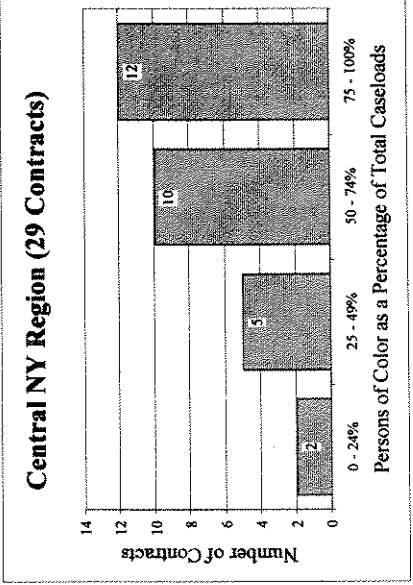
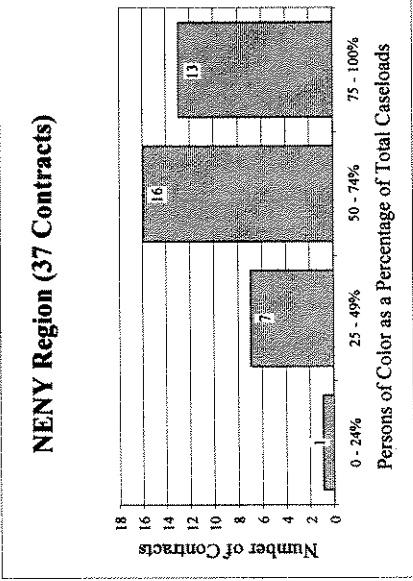
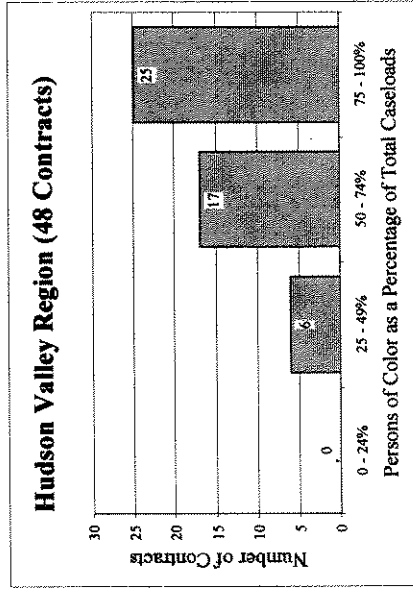
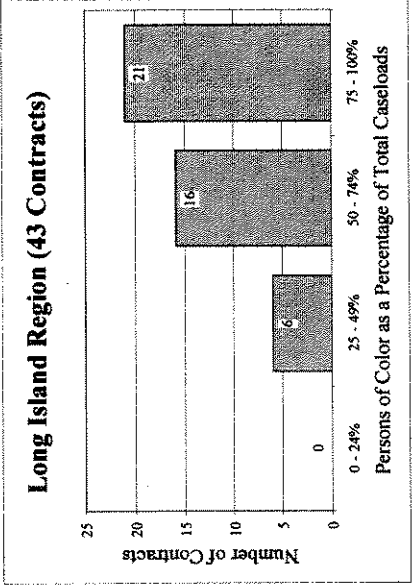
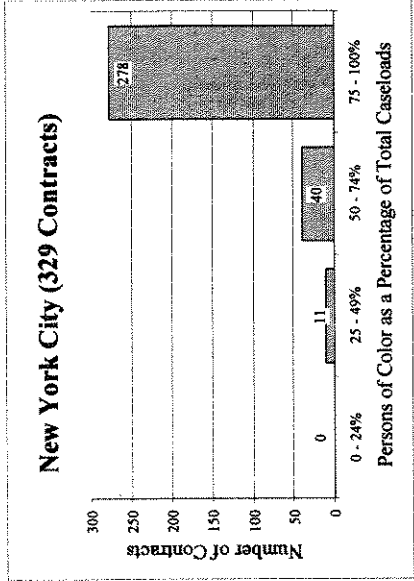
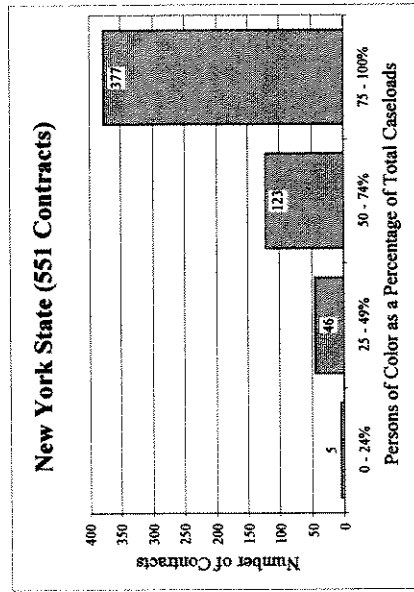
#### Prevention

• Contracts			
- Prevention	\$41.1M		
- Infrastructure/Other Costs	\$ 8.4M		
			\$38.3M State
<b>Total - Prevention</b>		\$49.5M	\$11.2M Federal

#### Health Care/Support Services

		\$39.2M State	
• Contracts	\$ 57.4M		
		\$18.2M Federal	
• Uninsured Care Pools			
- (Projected 99-00 Expenditures)	\$143.5M		
<b>Total - Health Care/Support Services</b>		\$200.9M	

# Distribution of AIDS Institute Contracts by Percentage of Total Caseloads Attributed to Persons of Color, FY '98-'99



## **Appendix III**

### **HIV/AIDS and Communities of Color Websites**

---

**AIDS and the Latino Community**

<http://c1net.ucr.edu/research/aids/aidscomm.html>

**AIDS in Prison Project**

<http://www.aidsinfonyc.org/aip/index.html>

**AIDS Services In Asian Communities (ASIAC)  
(Philadelphia)**

<http://www.critpath.org/asiac/>

**American Indian/Alaska Native Health Resources on the Internet**

<http://www.tribalconnections.org/>

**American Indian Community House (AICH)  
(New York)**

<http://www.abest.com/~aichnyc/index2.html>

**American Indian Health Central**

<http://members.tripod.com/~AIHC1998/>

Health Section

<http://AIHC1998.tripod.com/health.html>

**American Red Cross - HIV/AIDS Education**

<http://www.red-cross.org/hss/HIVAIDS/index.html>

African-American

<http://www.red-cross.org/hss/HIVAIDS/afam/index.html>

AIDS-related sites

<http://www.red-cross.org/hss/HIVAIDS/afam/related.html>

Hispanic

<http://www.red-cross.org/hss/HIVAIDS/hispanic/index.html>

Youth

<http://www.red-cross.org/hss/HIVAIDS/youth/index.html>

**Asian and Pacific Islander AIDS Agencies**

<http://hivinsite.ucsf.edu/topics/apis/2098.23b9.html>

**Asian & Pacific Islander American Health Forum**

<http://www.apiahf.org/>

**Asian and Pacific Islander Coalition on HIV/AIDS**

<http://www.apicha2.org/>

**The Balm in Gilead**

<http://www.balmingilead.org/>

**Black Coalition on AIDS (BCA)**

<http://www2.bcoa.org/bcoa/>

**The Body: an HIV/AIDS Information Resource**

Gay Men and HIV/AIDS

<http://www.thebody.com/whatis/gaymen.html>

Substance Use and HIV/AIDS

<http://www.thebody.com/whatis/druguse.html>

**Brown University**

Center for Alcohol and Addiction Studies

<http://center.butler.brown.edu/>

**Center for AIDS Prevention Studies (CAPS)**

University of California San Francisco

Young Asian Men's Study

<http://www.caps.ucsf.edu/projects/yamsindex.html>

**Centers for Disease Control and Prevention**

Minority reports

<http://www.cdc.gov/hiv/pubs/mmwr011400.htm>

National Center for Health Statistics

<http://www.cdc.gov/nchs/default.htm>

National Center for HIV, STD and TB Prevention

Divisions of HIV/AIDS Prevention

<http://www.cdc.gov/hiv/dhap.htm>

<http://www.cdc.gov/nchstp/od/nchstp.html>

National Prevention Information Network

<http://www.cdcpin.org/start.htm>

HIV/AIDS Resources

<http://www.cdcpin.org/hiv/start.htm>

**Columbia University**

National Center on Addiction and Substance Abuse

<http://www.casacolumbia.org/>

National Center for Children in Poverty

<http://cpmcnet.columbia.edu/dept/nccp/>

**Correctional HIV Consortium**

<http://www.silcom.com/~chc/>

**Emory University**

Rollins School of Public Health (RSPH)

Institute for Minority Health Research

<http://www.sph.emory.edu/bshe/imhr/>

**Gay Men's Health Crisis**

<http://www.gmhc.org/>

**Harm Reduction Services for Injection Drug Users**

<http://family.hampshire.edu/~harmred/harm2.html>

**Harvard AIDS Institute**

<http://www.hsph.harvard.edu/Organizations/hai/home.html>

Leading for Life

Unidos Para la Vida

<http://www.hsph.harvard.edu/Organizations/hai/leading/leading.html>

African-American sites

<http://www.hsph.harvard.edu/Organizations/hai/leading/afroamersites.html>

<http://www.hsph.harvard.edu/Organizations/hai/leading/summit.html>

Hispanic sites

[http://www.hsph.harvard.edu/Organizations/hai/leading/latino\\_summit.html](http://www.hsph.harvard.edu/Organizations/hai/leading/latino_summit.html)

**Hispanic AIDS Awareness Program**

(Miami)

<http://www.emservices.com/haap.htm>

**Hispanic AIDS Forum**

(New York)

<http://www.hispanicfederation.org/agencies/haf.htm>

**HIV Insite**

African-Americans

[http://HIVInSite.ucsf.edu/topics/african\\_americans/](http://HIVInSite.ucsf.edu/topics/african_americans/)

Asian Americans and Pacific Islander Americans

[http://HIVInSite.ucsf.edu/topics/asian\\_americans\\_and\\_pacific\\_islander\\_americans/](http://HIVInSite.ucsf.edu/topics/asian_americans_and_pacific_islander_americans/)

Gay Men & Men Who Have Sex with Men

[http://HIVInSite.ucsf.edu/topics/gay\\_men\\_men\\_who\\_have\\_sex\\_with\\_men/](http://HIVInSite.ucsf.edu/topics/gay_men_men_who_have_sex_with_men/)

Injection Drug Users

[http://HIVInSite.ucsf.edu/topics/injection\\_drug\\_users/](http://HIVInSite.ucsf.edu/topics/injection_drug_users/)

Latinos & Hispanic Americans

[http://HIVInSite.ucsf.edu/topics/latinos\\_hispanic\\_americans/](http://HIVInSite.ucsf.edu/topics/latinos_hispanic_americans/)

Native Americans

[http://HIVInSite.ucsf.edu/topics/native\\_americans/](http://HIVInSite.ucsf.edu/topics/native_americans/)

Women

<http://HIVInSite.ucsf.edu/topics/women/>

**Indian Health Service - HIV Center of Excellence**

(Phoenix)

<http://www.ihs.gov/MedicalPrograms/Aids/index.asp>

**Johns Hopkins University AIDS Service**

<http://www.hopkins-aids.edu/>

**Latinos Unidos Contra El Sida**

(New York)

<http://www.hispanicfederation.org/luces.htm>

**National AIDS Treatment Information Project**  
HIV Infection in Persons Using Injection Drugs  
<http://www.natip.org/ivdu.html>

**National Asian and Pacific Islander HIV/AIDS Policy Recommendations**  
<http://kali.ucsf.edu/topics/apis/2098.2d02.html>

**National Black Leadership Commission on AIDS (BLCA)**  
<http://www.blca.org/>

**National Minority AIDS Council**  
<http://www.nmac.org/welcome.htm>  
NMAC - links  
<http://www.nmac.org/Kioskpublic/minor.htm>

**National Institutes of Health**  
**National Institute of Allergy and Infectious Diseases**  
Minorities and HIV Infection Factsheet  
<http://www.niaid.nih.gov/factsheets/Minor.htm>

**National Native American AIDS Prevention Center**  
<http://www.nnaapc.org/>

**National Network of Libraries of Medicine**  
HIV / AIDS: Education and Prevention  
for Native Americans/Alaska Natives  
<http://www.nlm.nlm.nih.gov/pnr/samplers/naaids.html>

**New York City Department of Health**  
<http://www.ci.nyc.ny.us/html/doh/home.html>  
AIDS Surveillance Report  
<http://www.ci.nyc.ny.us/html/doh/html/dires/dir aids.html>  
Bureau of HIV Prevention  
<http://www.ci.nyc.ny.us/html/doh/html/ah/ah.html>

**New York State Department of Health**  
<http://www.health.state.ny.us/>  
HIV/AIDS in New York State surveillance data  
<http://www.health.state.ny.us/nysdoh/research/hiv aids.htm>  
HIV Counseling and Testing sites  
<http://www.health.state.ny.us/nysdoh/aids/hivtesti.htm>

**Stop AIDS Project**  
(San Francisco)  
<http://www.stopaids.org/>  
Organizations for People of Color  
<http://www.stopaids.org/Otherorgs.html#Color>



**University of California San Francisco**

Center for AIDS Prevention Studies (CAPS)

Collaborative HIV Prevention Research in Minority Communities

<http://www.caps.ucsf.edu/projects/minorityindex.html>

African-American Men's Health Study:

An HIV Prevention Program for African-American Gay and Bisexual Men

<http://www.caps.ucsf.edu/capsweb/projects/AAMHSindex.html>

**U.S. Census Bureau**

<http://www.census.gov/>

Poverty

<http://www.census.gov/hhes/www/poverty.html>

**U.S. Department of Health and Human Services**

Center for Substance Abuse Prevention

Substance Abuse & Mental Health Services Administration

<http://www.samhsa.gov/csap/index.htm>

Congressional Black Caucus (CBC) Initiative

<http://www.hrsa.gov/hab/cbcindex.html>

HIV/AIDS Services

<http://www.hrsa.gov/hab/default.htm>

National Clearinghouse for Alcohol and Drug Information

Substance Abuse & Mental Health Services Administration

<http://www.health.org/>

Office of Minority Health Resource Center:

Initiative to Eliminate Racial and Ethnic Disparities in Health;

Hispanic Agenda for Action

<http://www.omhrc.gov/>

Office on Women's Health

National Women's Health Information Center

<http://www.4women.gov/>

**Youth HIV**

<http://www.youthhiv.org/>