

# IV Impact

## Positive Results

### *Community/Research Partnerships Bear Fruit*

Jennifer L. Rich

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When Laurell Lasenberg, the former president of the Central Harlem HIV/AIDS Network, was invited by the New York Academy of Medicine to join a group of local leaders in forming a community action board to address the borough's chronic public health problems, she thought: "Sure, why not?" But she, like others at the table, was uncertain of what the relationship would accomplish.

"When we first started, we would all just sit there and the principal investigator at the time would tell us about the research they were doing," she recalls. "Until somebody finally said: 'Why are we here?'"

The group hasn't looked back since. After developing a set of principles and a mission statement, they've embarked on a collaboration that has already begun to yield positive results.

Such relationships are beginning to spring up around the country as a growing number of government and private funders are betting that collaboration between researchers and community groups can be an effective way to address the nation's health problems. That's good news for community-based organizations looking for new revenue streams in today's increasingly competitive funding environment.

The value of community-based participatory research (CBPR), according to proponents, is that community organizations have a better understanding of the social and environmental factors that

affect health than do researchers, who tend to conduct their studies in a vacuum. With health disparities among racial and ethnic minorities becoming an increasingly important focus of federal, state and

local public health outreach, the research community has started to turn to the community for their help in developing culturally appropriate programs.

"Things developed by brilliant minds in ivory

towers always fail," said David Vlahov, the director of the Center for Urban Epidemiologic Studies (CUES) at the New York Academy of Medicine. "When the community is involved, it becomes vested, and having that personal stake makes it work."

Funders seem to agree. In an August 2003 article in the "American Journal of Public Health," Meredith Minkler, a researcher at University of California, Berkeley, points out that government funding has played an instrumental role in spurring CBPR in the United States. And philanthropic organizations like the W.K. Kellogg Foundation, the Ford Foundation, the Annie E. Casey Foundation, the California Endowment and the Aspen Institute have also begun throwing significant support behind CBPR.

While the dollar amounts are still low, Minkler says that momentum is gathering for what Lawrence W. Green, director of extramural prevention research at the Centers for Disease Control and Prevention (CDC) has called "bootstrap epidemiology." For example, she said, the CDC recently funded \$13 million in three-year CBPR grants. The

*"It's important to provide everyone with flexibility and a sense of control..."*

David Vlahov

Center for Urban Epidemiologic Studies



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Office of Minority Health,  
U.S. Department of  
Health and Human Services

CDC also supports three urban research centers, including CUES, that focus strictly on community-based research.

### Who's at the Table?

The key to organizing an effective community-based research program, according to Vlahov, is to include a wide variety of organizations at the table. CUES invited the leadership from health-related organizations, such as HIV/AIDS groups and city and state health departments, multi-service clinics, substance abuse treatment centers, homeless shelters and correctional facilities. The only prerequisite was that the groups have a firm stake in the community.

Though most of the community leadership responded positively to the invitations, they often were too busy to participate themselves, sending midlevel management instead. The lack of decision-making power at the table was CUES' first challenge.

"You get a number of people who can communicate information back and forth but there is still some higher level of integration that is missing," Vlahov said. "The people that we got were terrific, but learning what we have learned, we would go for the executive directors."

### Starting Simple

One of the early challenges of CBPR, according to participants, is to find common ground among the varied interests, which can begin only as the groups start to understand each other's vocabularies. The extended ramping-up time can be worrisome to results-oriented funders, so Vlahov recommends pushing for some quick successes.

On the CUES community action board, for example, the group ultimately decided to work toward the goal of making it easier to get treatment for injection drug use in Harlem than to get the drugs themselves. That broad goal has allowed them to focus on related problems such as HIV and Hepatitis C, housing, treatment and health disparities.

Their first quick effort was to develop a "Survival Guide" of support services for drug users and their families. In order to increase communication between the providers themselves, the group also created an Internet-based resource guide ([www.harlemresourceguide.org](http://www.harlemresourceguide.org)) where local community-based organizations can both search for services and update their own program information.

The two successes brought the group members closer together, Lasenberg said, and reinforced the ties between their organizations.

"What we are trying to get across to people is that you are

not just dealing with HIV when you are dealing with a person living with AIDS," Lasenberg said. "It is important for service providers to have linkages to other service providers and to the Academy of Medicine."

### Building Trust

The first few successes also helped to build trust among groups that often compete for resources.

Part of the way the Academy compensates its board members is through free grant writing seminars. The organization also provides meeting space. And it has a small amount of money available for grants within the community.

One of the more important aspects of the relationship, Lasenberg said, is that it gives community-based organizations the access to researchers who can provide data for grant proposals.

"You cannot send an RFP or an RFA without statistics, without data, without some type of the research to show that your program is going to work for a certain population," Lasenberg said. "So now we call up the Academy and say, 'Listen, I have this program that I want to do and I need this information.' And they say, 'Fine, no problem.'"

Ultimately, though, the community action group will be competing for funding that everyone can share in some way.

Vlahov said he explained the premise to the group in this way: "Some grants are just going to make sense for us to do. But then there are going to be times where we sit down and do something as a joint venture. You will get half the funding. Your names will be on the papers. You'll get to go to national meetings."

"It's important to provide everyone with flexibility and a sense of control," Vlahov said. "What is it that we can get out of it? What is it that the other side can get out of it? Everyone needs to feel that it is fair and equitable."

### How Does It Work Now?

After a year, the CUES group has moved on to bigger projects that have begun through simple brainstorming. Eventually, questions boil down to: Who might the project serve and what can it do? Is it something that can be done in a reasonable amount of time? Do they have the right kinds of people? Is there interest all the way around? And finally, do they feel comfortable going forward?

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*HIV Impact is a free newsletter of the Office of Minority Health, Office of Public Health and Science, U.S. Department of Health and Human Services.*

*The Office of Minority Health Resource Center provides free information on various health issues affecting U.S. minorities.*



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The community action board recently gave the go-ahead to an influenza immunization project.

Vlahov explains: “We picked influenza because it’s an easy one. If you have a pandemic, it is going to be awful for everyone, but 40 percent of these people have never seen a doctor and they won’t go to a clinic, so how do you reach them?”

The community action group decided to address the problem by mobilizing HIV groups that have extensive contact with the community. Through an “Adopt a Block” approach, the outreach workers are going to go door to door to talk to people directly about the influenza vaccine.

“We’re taking an infrastructure that was set up for HIV and expanding it to other pre-primary care outreach for public health prevention,” Vlahov said.

“The ultimate goal here is to get immunizations up in general,” he added. “In East Harlem, only seven percent of people have gotten a Hepatitis B vaccine, despite the fact that the vaccine has been available for more than 20 years. There is eventually going to be an HIV vaccine. How are you going to distribute it?”

If vaccines work, he said, they can expand the outreach to other health issues, while keeping the core HIV message.

### Where to look?

Though not many areas have CBPR programs like CUES in New York, Vlahov says that CBOs can look for community/research partnerships in a variety of locations. The first, he said, is through schools of public health at local universities. The proportion of faculty that does research in the local area is small, he said, but there are those that are committed to community health issues.

He also suggests contacting local health departments, which are more and more interested in building links with the community for joint problem-solving.

For more information, call 212-822-7200 or go to <http://www.nyam.org/initiatives/cues.shtml> ♦

## Why Parents Matter

Jennifer L. Rich

By looking at him, you wouldn’t suspect that James Austin makes people nervous. He’s not a big man. He speaks in a calm, college professor-like voice. It’s what he says that causes the anxiety. Because when he walks into a room, people know he is going to talk to them about sex.

Austin is one of a handful of facilitators for Georgia State University’s Parents Matter program who go into communities around Atlanta to teach African American parents how to talk to their children about sexual risk and HIV prevention.

“They know you come from a university setting and you are dressed in nice clothes and they figure you must be a doctor or something,” Austin said. “I tell them no, I’m not a doctor, I’m not a health worker, I’m a parent, like you.”

The Parents Matter program was founded at the Institute of Behavioral Research at the University of Georgia after years of research showing the benefit of early parental involvement in shaping the decisions of children.

“Parents can provide accurate information and teach values and skills needed to make responsible decisions about health early, before risk behaviors are established,” said Kim Miller of the Centers for Disease Control and Prevention (CDC). “And compared to other sources of information, parents hold the reputable distinction of having an audience that wants to hear from them.”

In collaboration with researchers at Georgia State and the University of Arkansas for Medical Sciences, the CDC-funded study recruited 1,200 African American families that included a parent, co-parent, and child in the fourth or fifth grade. To qualify for the study, the primary caregiver had to be living with the child for the previous three years. Parents were asked to attend

a series of sessions that focused on three major topics: risk awareness, positive parenting and sexual communication skills.

Scyatta Wallace, a research fellow at the CDC, said that risk awareness is the cornerstone of the program. Even though half of all HIV infections occur in people under 25, she said, “Many parents are unaware of the early initiation of sexual intercourse among many youth and of the consequences from sexual risk behaviors.”

In the positive parenting section, parents talk about how to build strong lines of communication with their children.

“Sometimes parents don’t communicate with their kids,” Austin said. “Sometimes whole weeks can go by, and the parents don’t know about the things that happen in their child’s life.”

To reinforce the idea of positive communications skills, Austin says that they ask parents to discuss what they like about their supervisors at work. Answers usually include: someone who’s understanding, someone who listens, and someone who considers all the facts before making a decision. Then Austin asks them how they treat their own children.

“It stops them in their tracks,” Austin said. “Because a lot of times all of the relationship is directed at the child: ‘You do exactly what I tell you to do, when I tell you to do it.’”

“What we try to make the parents realize is that as high as the stakes are, communication is essential,” he added.

Once the facilitators have worked on general communication skills, they turn their focus to increasing the parents’ ability to talk about sex.

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# From Mother to Daughter

## *Project Teaches Latinas that HIV Education Starts at Home*

Jennifer L. Rich

What do 80 Latinas from the gritty Mission district of San Francisco and the sleepy agricultural community of Watsonville 90 miles to the south have in common?

All have daughters between the ages of 11 and 18. All want their daughters to have a better life than they did. And all took part in a four-day curriculum all in Spanish to teach them how to better communicate with their daughters about sexual health and HIV prevention.

Called "From Mother to Daughter: Protecting Our Health," this intergenerational pilot initiative developed by a team of researchers from the University of California, San Francisco (UCSF) highlights a fact that is often overlooked in HIV prevention programs directed at the Hispanic community: the positive role parents can play in helping guide their children's sexual development.

"Parents recognize that their kids are vulnerable and they want to be good teachers of sexuality to them," said Cynthia Gómez, principal investigator for the project and interim director of the Center for AIDS Prevention Studies (CAPS) at UCSF. "I don't think that is a surprise, but Latinos aren't usually viewed that way."

Indeed, many people think that religiosity keeps Latinos from talking about sexual health. But Gómez said that data from large-scale studies have failed to find a connection. Instead, she says that gender role traditions and a lack of knowledge are much more influential, a fact that became obvious to the UCSF team from pre-study focus groups.

"What was fairly amazing for us is the degree to which women did not know the basic anatomy of men and women," Gómez said. "If women don't even know how their bodies, and particularly their genital areas, function, how will they understand why they are making certain decisions around precautions for HIV or STDs?"

And how, she asks, are they supposed to communicate that information to their daughters, who may already know more than they do through sex education classes at school.

"These women were embarrassed to talk to their daughters," she said. "And justifiably so, because their daughters could say: 'You don't know this? How can you possibly help me?'"

In response, Gómez and her colleagues created a curriculum that focused heavily on anatomy, as well as sexual health and risk, communications skills, and intergenerational issues.

"Parents need to feel confident in communicating their

expectations to their teens and preteens and teaching them that waiting to have sex until they are married or in a committed, long term adult relationship is the healthiest choice they can make," said Dr. Alma Golden, the deputy assistant secretary for Population Affairs. "Young people who are abstinent do not have to worry about pregnancy or sexually transmitted diseases, including HIV/AIDS. Condoms may reduce the chances of infection or pregnancy, but they do not reduce the emotional and social impact of sex on teens. Only abstinence works 100 percent of the time, and parents are important partners to provide support for abstinence."



After several hours of in-depth discussion on the anatomy of sexuality, Gómez said the women were already starting to feel more confident. "They left the session saying 'Now I'm going to know more than my daughter,'" she said.

But that's just the tip of the iceberg. In pre-project focus groups, girls surprised the researchers by saying that they were actually much more interested in emotional guidance than a lecture on the birds and the bees.

"They feel like they know about sex ed from school, but they want to know about relationships with boys," said Angelica Martinez, field coordinator for the study in San Francisco. "How to have a healthy relationship is not talked about so if they are being abused, they think it's normal."

Part of the problem, Martinez said, is that the mothers were too overcommitted with work and other responsibilities to talk to their daughters much at all.

"One girl told me that she had a friend whose mom takes her out to lunch every week so that they can be alone to talk," Martinez said. "She said her mom was always working, she was always busy."

In response, a segment of the curriculum asks mothers to set goals for creating time to talk to their daughters alone.

The curriculum also includes a section on fostering conversation. Instead of communication-stoppers like "You can't have a boyfriend until you are 21," mothers were instructed to soften their language to "Although I'd like you to wait, if you do decide to have a boyfriend, I'd prefer to know about it."

As part of an exercise on intergenerational values, women were also asked to explore their families' feelings about sexual topics. The message, Martinez said, was: "We definitely want

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# De madre a hija

## *Enseñando a las latinas que la educación sobre el VIH comienza en casa*

Jennifer L. Rich

Translation by Isabel Estrada-Portales, M.S.

¿Qué tienen en común 80 latinas del árido distrito Mission de San Francisco y la adormecida comunidad agrícola de Watsonville, que queda 140 km (90 millas) al sur? Todas tienen hijas entre las edades de 11 y 18 años. Todas quieren que sus hijas tengan una vida mejor que la que ellas han tenido. Y todas participaron en un seminario en español de cuatro días, para enseñarles a comunicarse con sus hijas sobre salud sexual y prevención del VIH.

Con el título “De madre a hija: Protegiendo nuestra salud”, esta iniciativa intergeneracional piloto desarrollada por un equipo de investigadores de la Universidad de California, San Francisco (UCSF) subraya un aspecto a menudo ignorado en los programas de prevención del VIH dirigidos a la comunidad hispana: el papel positivo que los padres pueden jugar en la guía del desarrollo sexual de sus hijos.

“Los padres reconocen que sus hijos son vulnerables y quieren ser buenos maestros de sexualidad para ellos”, dijo Cynthia Gómez, investigadora principal del proyecto y directora interina del Centro de Estudios para Prevención del SIDA (CAPS, por sus siglas en inglés) en la UCSF. “No creo que sea una sorpresa, pero los latinos no son vistos de esa forma usualmente”.

De hecho, muchas personas piensan que la religiosidad hace que los latinos eviten hablar sobre salud sexual. Pero Gómez dijo que los datos de estudios a gran escala no han encontrado ninguna conexión entre ambos aspectos. En lugar de esto, ella dice que las tradiciones de los roles de géneros y la falta de conocimiento tienen mucha más influencia, algo que se manifestó abiertamente al equipo de UCSF en los grupos de foco previos al estudio.

“Lo que nos resultó realmente sorprendente fue el grado de desconocimiento de las mujeres con respecto a la anatomía básica de mujeres y hombres”, dijo Gómez. “Si las mujeres ni siquiera saben cómo funcionan sus cuerpos, y en particular sus genitales, ¿cómo van a comprender por qué toman determinadas decisiones relativas a las precauciones contra el VIH o las enfermedades de transmisión sexual (ETS)?”

Y cómo, pregunta Gómez, pueden ellas comunicar esa información a sus hijas, quienes pueden saber ya más que sus madres a través de las clases de educación sexual recibidas en la escuela.

“Estas mujeres sentían vergüenza de hablar con sus hijas”, dijo ella. “Y con razón, porque sus hijas podían decirles: ‘¿Tú no sabes eso? ¿Cómo puedes ayudarme, entonces?’”

Como respuesta, Gómez y sus colegas crearon un currículum con énfasis principalmente en anatomía, así como salud sexual y riesgo, habilidades de comunicación y problemas generacionales.

“Los padres necesitan comunicar, con seguridad, sus expectativas a sus hijos adolescentes y enseñarles que la opción más saludable es esperar a casarse o a estar en una relación amorosa estable y adulta para comenzar las relaciones sexuales”, dijo la Dra. Alma Golden, la secretaria asistente de Asuntos de la Población. “Los jóvenes que se abstienen no tienen que preocuparse del embarazo o de

las enfermedades de transmisión sexual, incluido el VIH/SIDA. Los condones pueden reducir las probabilidades de infección o embarazo, pero no reducen el impacto emocional y social del sexo en los adolescentes. Sólo la abstinencia es 100 por ciento efectiva y los padres son importantes en el apoyo a la abstinencia”.

Después de varias horas de profunda discusión sobre la anatomía de la sexualidad, Gómez dijo que las mujeres comenzaron a sentirse con más confianza. “Ahora yo voy a saber más que mi hija”, dijo.

Pero eso es sólo la punta del iceberg. En los grupos de foco previos al proyecto, las muchachas sorprendieron a los investigadores al decirles que ellas estaban mucho más interesadas en guía o acompañamiento emocional que en una conferencia sobre las cigüeñas.

“Ellas sienten que saben sobre educación sexual por la escuela, pero quieren saber más sobre las relaciones con los muchachos”, dijo Angelica Martínez, coordinadora de campo del estudio en San Francisco. “No se habla sobre cómo tener una relación saludable, por tanto, si ellas están siendo abusadas, ellas creen que es normal”.

Parte del problema, dice Martínez, tenían demasiadas responsabilidades con trabajo y otras cosas y no tenían oportunidad de hablar con sus hijas sobre nada.

“Una muchacha me dijo que ella tenía una amiga a quien su mamá la llevaba a almorzar todas las semanas para tener tiempo de estar solas y conversar”, dijo Martínez.



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# Creating Awareness One Day at a Time

## *National Black HIV/AIDS Awareness and Information Day*

Jennifer L. Rich

The freezing rain that fell most of the day didn't stop 400 people from coming to the Frank D. Reeves Municipal Building in downtown Washington, D.C., on Friday, February 6, 2004, to get tested for the virus that causes AIDS. The event, which included a health fair, was just one of hundreds of activities across the country organized in recognition of the Fourth Annual National Black HIV/AIDS Awareness and Information Day on February 7.

"National Black HIV/AIDS Awareness and Information Day is an important opportunity to understand and educate people nationwide about mobilizing in the fight against HIV/AIDS," said Tommy G. Thompson, secretary of the Department of Health and Human Services.

The need for the day is more compelling than ever, supporters say. Though African Americans make up 12 percent of the U.S. population, they comprised 51.7 percent of all estimated AIDS cases diagnosed in 2002. HIV/AIDS is one of the top three leading causes of death for both African American men and women ages 25-44.

"The thing about HIV is that it wreaks havoc on our economics as well as our social structures," said LaMont Evans, executive director of Concerned Black Men, Inc. of Philadelphia, one of the groups that founded the day. "Once we get people educated about the disease, everything gets better."

Around 215 events took place throughout the country,

including prayer breakfasts, rallies, music and dance presentations, workshops and health fairs, to mobilize African Americans from all communities and walks of life to address the disease.

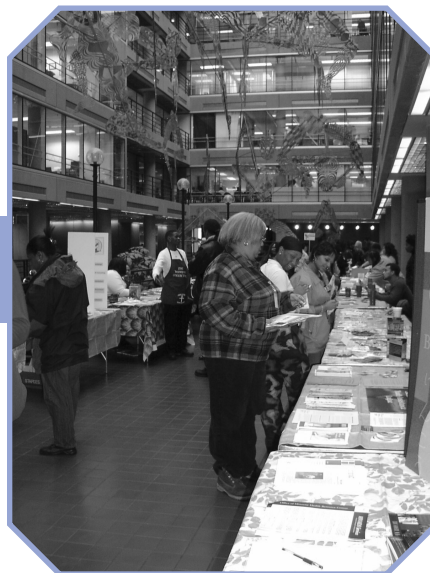
"If we are to end the HIV pandemic in African Americans, African Americans must continue to be part of the solution, as clinicians, prevention providers, treatment advocates, researchers and as HIV therapeutic and preventive vaccine clinical trial volunteers," said Dr. Anthony Fauci, director of the National Institute of Allergy and Infectious Diseases at the National Institutes of Health.

National Black HIV/AIDS Awareness and Information Day was created by the Community Capacity Building Coalition, a group made up of Concerned Black Men, Inc. of Philadelphia, the Mississippi Urban Research Center at Jackson State University, Health Watch Information and Promotion Service, the National Black Alcoholism & Addiction Council and the National Black Leadership Commission on AIDS. Besides organizing National Black HIV/AIDS Awareness and Information Day, the Coalition receives funds from the Centers for Disease Control and Prevention to provide HIV/AIDS prevention capacity-building assistance to community-based organizations in African American neighborhoods.

"If one person walks away from today knowing more about HIV, we would consider the day a success," Evans said. ♦



Hundreds visit the Frank D. Reeves Municipal Building in downtown Washington, D.C., in recognition of the Fourth Annual National Black HIV/AIDS Awareness and Information Day.



For more information on National Black HIV/AIDS Awareness and Information Day, visit the HHS Web page dedicated to the initiative at <http://www.omhrc.gov/blackaidsday> ♦

# Ask An Expert

## *Microbicides*

Roberta Black, Ph.D.

In the United States, 20 African American women are infected with HIV every day. A surge in new infections among U.S. Latinas means that they are seven times more likely than White women to contract HIV. And it doesn't stop there. Worldwide, women represented almost half of the estimated 42 million people infected with HIV at the end of 2002.

Most disturbing about these statistics is that minority women acquire HIV predominantly through unprotected sexual intercourse. Yet, for protection, sexually active women largely have only one recourse: the consistent and correct use of male condoms. The catch, of course, is that men must agree to use them. Such cooperation may be unrealistic, however. Even when one partner thinks a relationship is monogamous, the risky sexual practices of the other may remain undisclosed. The vulnerability of women of all ages drives the development of safe, effective and acceptable female-controlled methods for preventing the sexual transmission of HIV. Microbicides may provide an answer.

Topical microbicides are preparations for intravaginal or intrarectal application that contain chemical and/or biological mediators to prevent infection by HIV and other sexually transmitted pathogens. Topical microbicides could, in theory, act at multiple levels to repel HIV infection by:

- Directly inactivating the virus by (i) enhancing or stimulating the natural acidity of the vagina, or (ii) disrupting a viral membrane;
- Preventing the infection of susceptible cells with HIV reverse transcriptase inhibitors or by impeding the binding and entry of the virus;

- Blocking the dissemination of HIV from initial target cells to other susceptible cells by interrupting the attachment to specific cellular receptors; and
- Inhibiting sexually transmitted infections (STIs), which create abrasions in the lining of the vagina and/or cervix that can help HIV gain access to susceptible cells.

Based on what we know about optimizing HIV therapeutics, it is likely that the most effective topical microbicide will contain a cocktail of active ingredients with diverse mechanisms to act against HIV and other STIs. In addition to having potent inhibitory activity, an ideal microbicide would have to:

- Be safe for multiple daily applications over long periods of time;
- Act rapidly and be long lasting;
- Either be acceptable to both sexual partners or be completely unobtrusive;
- Be inexpensive and available over the counter;
- Remain where applied while distributing appropriately to cover all relevant tissues, without leaking or being absorbed systemically; and
- Be compatible with the body's microbial ecology.

There are approximately 70 candidates at various stages in the microbicide development pathway. Although ample precedent suggests that topical agents could possibly protect against HIV and other STIs, the most urgent priority in

microbicide research and development is to prove clinical efficacy. Six microbicide candidates should enter advanced clinical trials by the second quarter of 2005.

Despite progress, though, challenges still remain. Certain elements of the clinical trial design still need to be hammered out. For example, researchers have not decided on the best placebo. And limited international clinical trial infrastructure raises issues about capacity and feasibility.

We also need to have a better understanding of what makes a product acceptable to the culturally diverse group of women it is being developed to serve. The most potent microbicide is no good if women refuse to use it correctly and consistently.

It will probably take five to seven years for one or more of these first candidates to make it to market, assuming clinical trials prove they are safe and at least partially effective. While less than ideal, an initial success would provide an important springboard for the rapid development of highly improved second and third generation products.

*Roberta Black, Ph.D., is Team Leader for Topical Microbicides at the National Institute of Allergy and Infectious Diseases.*

*For more information, go to the National Institutes of Health Office of AIDS Research at [http://www.nih.gov/od/oar/about/research/microbicides/oar\\_micro.htm](http://www.nih.gov/od/oar/about/research/microbicides/oar_micro.htm)*

**Clinical Trial Candidate**  
Mechanism

**BufferGel™**  
maintains vaginal acidity

**PRO 2000/5™, Dextrin-2-sulfate™, Carraguard™, Cellulose sulfate™**  
prevents the entry of HIV or other STIs into initial target cells

**Saavy™**  
disrupts the cell membranes of HIV or other STIs

# Serving the Few and Far Between

## *Maui AIDS Foundation*

Jennifer L. Rich

With the shockingly blue ocean lapping softly on the rocks below, more than a hundred Native Hawaiians, Asians and Pacific Islanders recently gathered at a YMCA camp on the tip of Maui's Keanae Peninsula\* for a weekend of HIV prevention and cultural activities organized by the Maui AIDS Foundation. Speakers from local and national minority health groups addressed the diverse crowd of at-risk gay, straight or transgendered men and women in a spot where Native Hawaiians still fish and farm the soil for taro root.

"Keanae is spiritually significant because no blood was ever shed there," said Dean Wong, the director of education and prevention at the Maui AIDS Foundation. "Native people immediately feel like they are in a safe place there, so we don't have to spend a lot of time breaking down walls."

Sponsored in part by the Office of Minority Health, the second annual Native Hawaiian, Asian and Pacific Islander Retreat to Paradise is one of a number of creative ways the Maui AIDS Foundation is adapting urban interventions to serve a culturally unique mix of Native Hawaiians, Asians and Pacific Islanders.

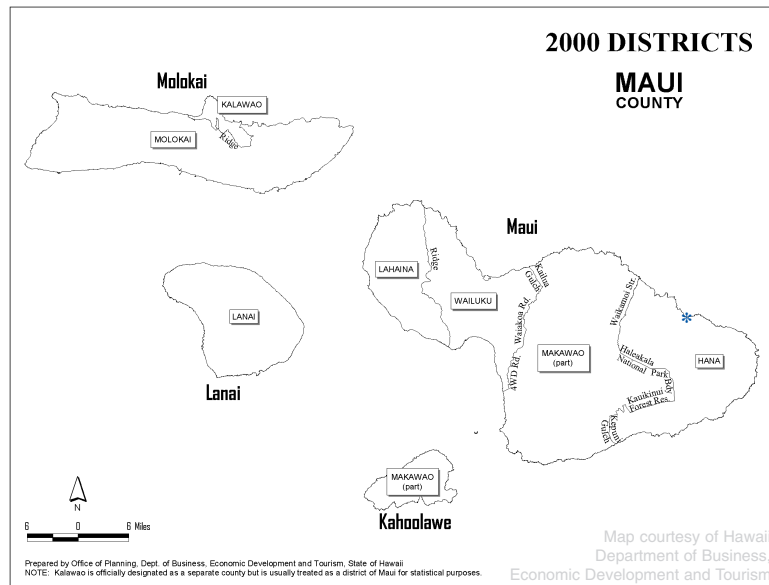
"It's because so many communities are out of sight and out of mind that HIV and AIDS are able to survive so well," said Jay Blackwell, director of HIV education and training at the Office of Minority Health Resource Center. "Maui AIDS is taking a leadership role in serving underserved and unrecognized communities at high risk for an HIV and AIDS explosion."

The Maui AIDS Foundation was founded in 1986 by a group of concerned citizens soon after the first known AIDS case was diagnosed on the island. The group received its first government funding three years later, after struggling to convince the state that the residents of Maui were not being effectively served by organizations from the island of Oahu, which has 80 percent of Hawaii's population but lies nearly 100 miles away.

"The neighbor islands have always felt that we are forgotten or not considered as much because we have such small population bases," said Jon Berliner, the executive director of Maui

AIDS since 1994. "One by one, each neighbor island county developed its own AIDS organization and they had to do a lot of educating to get the state to see that there was an important need in each place."

Hawaii is made up of eight major islands. Maui County, which has a population of around 120,000, oversees three of them: the largest, Maui itself, as well as neighboring Molokai with 7,000 people and Lanai with around 3,000. Kahoolawe, unpopulated, is usually treated as a district of Maui for statistical purposes.



All are largely rural, and have significant populations of Native Hawaiians and other Asian and Pacific Islanders, which makes HIV interventions challenging.

"Models around prevention that are usually tested and tried in urban centers and rolled out across the United States don't really address our cultural issues," Wong said. "We have to readapt them to bring them into our culture in a way that is not threatening."

For example, he said that group-level interventions for people who are HIV positive don't work in Maui's rural setting, where those with the virus fear revealing their serostatus. A typical one-on-one risk assessment for an HIV negative individual is also spurned by the locals for being threatening and cold.

"We have an expression about how you get to know people here in Hawaii called 'talk story,' which means that you talk about their family, you talk about their kids, you talk about their aunts and uncles and nieces and nephews and what school they went to," Wong said. "Once you've shared all that information, you can start exchanging other information, but it has to come from a place of brotherhood, not 'I'm the White missionary who has come to your island to teach you something.'"

Wong said that Asian and Pacific Islander men who have sex with men (MSM) also have a very different way of responding to interventions than the White gay community.





Photo/Jay Blackwell

Overlooking the Keanae Peninsula, a men's group learns how to communicate HIV prevention.

“The White gay men who come to Hawaii come as couples, buy a house together and socialize in that capacity,” Wong said. In contrast, he said that Asians, Pacific Islanders and Native Hawaiians seldom reveal that they are gay. They usually remain at home with their families, and they might still get married and have children.

As a result, Maui AIDS has had to devise radically different interventions for each group. For the Native Hawaiians, Wong says that outreach workers often evoke memories of the leprosy epidemic that swept through the islands in the 19th and early 20th centuries, after colonizers exposed the nonresilient natives to the disease.

“AIDS and leprosy are really interchangeable here because native people feel like it came on them in the same way,” Wong said. “In our education efforts, we remind people about that by saying ‘It’s already here, it’s too late. But the difference between leprosy and AIDS is that we can prevent you from getting it because it is transferred based on what your behaviors are.’”

For native people, as well as the Asian and Pacific Islander communities, Wong and his team also draw on the tenets of eastern medicine in their prevention efforts.

“Eastern medicine is all about prevention, not about curing,” he said. “If you wait to get acupuncture until you have a pain in your neck, you’ve waited too long.”

Instead, adherents are supposed to continually work to keep themselves in harmony and balance, whether through meditation, Tai Chi or regular acupuncture. Illness, if it happens, means that energy is no longer flowing.

It is that same focus on prevention and traditional remedies, though, that stymies efforts to diagnose and treat those already infected with HIV.

“When Native Hawaiians find out that they have HIV, it is usually at the late stages of AIDS and they usually have one or

two weeks to live,” he said. “Testing is an invasive concept to them, and it is only when families feel like they can’t do anything else that they are taken to the hospital.”

The agency is currently serving 160 HIV-positive clients. According to Berliner, around 60 percent are ‘haole,’ a local term that refers to people not originally from Hawaii. A large number of those are White gay men who moved to the islands in the early years of the AIDS epidemic to live out their lives in “paradise.” An additional 30 percent of clients are Native Hawaiians, who have the fastest growing infection rate in the state. The remainder is a mix of Japanese, Chinese, Koreans and other Pacific Islanders.

“We know that there are some people out there who decide that they don’t need our services for whatever reason,” Berliner said. “But we are out in the community trying to bring down any barriers that might exist so that individuals are comfortable accessing our services.”

Often, that means meeting clients at their homes or in public parks.

“Having HIV/AIDS can be a stigma and being identified as gay or bisexual can be a stigma,” Berliner said. “Since everybody knows everybody here, clients are afraid that people will see them walking in our door.”

Maui AIDS has been able to step up its client services over the past five years or so by focusing heavily on outside fundraising. In 1998, the group convinced AIDS organizations on the neighboring Big Island and Kawai to form a coalition to help identify financial resources for all of the partners.

In 1999, that partnership led them to apply for a Housing Opportunities for Persons with AIDS (HOPWA) Special Projects of National Significance (SPNS) grant, which targets

Maui continued on 10

# Save the Date...August 12 - 15, 2004

## 2004 Minority Women's Health Summit

The theme for this summit, "Women of Color, Taking Action for a Healthier Life: Progress, Partnerships and Possibilities" will be held August 12-15, 2004, in Washington, D.C.

The 2004 Minority Women's Health Summit—sponsored by the Office on Women's Health—aims to build on the outcomes of the 1997 National Conference "Bridging the Gap: Enhancing Partnerships to Improve Minority Women's Health."

Over 500 professionals from diverse fields of expertise, including policy makers, public health officials, health care workers, medical institution researchers, employers, faith-and community-based organization advocates, allied health professionals and more are expected to attend.

The summit program will include plenary sessions focusing on national, state and community collaborations, along with breakout and poster sessions.

Key areas in women's health including cardiovascular disease, cancer, diabetes and HIV/AIDS will be highlighted among different minority groups—African Americans, American Indians and Alaska Natives, Asian Americans, Hispanics/Latinas, Native Hawaiians and other Pacific Islanders, Africans and Indians.

### Objectives for the Minority Women's Health Summit:

- ✓ Explore current prevention strategies that work in various communities, both urban and rural.
- ✓ Promote dialogue among policy makers, service providers, community women, academia and other stakeholders to address current health care issues for women of color.
- ✓ Recommend action-oriented strategies to increase positive health outcomes for women of color across the lifespan, from rural and urban communities.
- ✓ Foster community partnerships to identify and implement best practices that target prevention, diagnosis and treatment of diseases that disproportionately affect women of color.
- ✓ Promote strategies to diversify leadership in health sciences, education, research and policy.
- ✓ Ensure health issues of women of color remain at the forefront of national, state and local health policy agendas.

*For more information on the Minority Women's Health Summit, call 202-205-0571, or go to <http://www.4woman.gov/mwhs> ♦*

### Maui continued from 9

innovative, replicable projects for largely underserved populations, including racial and ethnic minorities, women and people living in rural areas.

Maui AIDS was one of 11 non-profit organizations nationwide that was awarded a \$1.1 million three-year SPNS grant that year, which it administrated with help from its partners. In 2003, the grant was renewed for \$1.6 million.

"We had been using a significant amount of our Ryan White emergency financial assistance funds for emergency rental assistance, and our clients were still becoming homeless or close to homeless because there was very little housing money available," Berliner said. "The grant has moved us up a level in the services we are able to provide to families living with HIV/AIDS."

These days, Berliner said that state budget cuts and decreasing private funding has once again forced them to spend much of their time looking for additional revenue sources.

His newest pet project, though, is to develop vocational programs that would help reintegrate people back into society who have been living with HIV for some time. He is swapping his fundraising expertise for help in developing the programs with an organization in San Francisco that has already had some success in bringing longtime HIV sufferers back to the workplace.

"Even though they are a large city and we are a small community, we still have a lot to share with each other," Berliner said. "That's really what it is all about; people within the health and human services sector sharing ideas and helping each other so that we aren't all reinventing the wheel."

*For more information on the Maui AIDS Foundation, call 808-242-4900, or visit <http://www.mauiaids.org> ♦*

## What's New?

### *The Latest from Health and Human Services*

#### AIDSinfo Help Line Now Live Online

**N**eed answers to your questions about federally approved information on HIV/AIDS treatment and prevention research, HIV/AIDS clinical trials, and treatment and prevention guidelines?

The National Institutes of Health's (NIH) educational Web site, AIDSinfo, recently launched "Live Help," an online service that provides individual, anonymous, confidential assistance to visitors experiencing difficulty navigating the AIDSinfo Web site or locating federally approved HIV/AIDS information.

The help line is available at <http://aidsinfo.nih.gov/> Monday through Friday, from 12:00 noon to 4:00 p.m. EST. Visitors can also contact Live Help staff via e-mail at [ContactUs@aidsinfo.nih.gov](mailto:ContactUs@aidsinfo.nih.gov), or the AIDSinfo Telephonic Information Service, available Monday through Friday, from 12:00 noon to 5:00 p.m. EST, at 301-519-0459 (International); 800-448-0440 (toll-free); or 888-480-3739 (TTY/TDD).

Live Help staff members are trained health information specialists with a detailed knowledge of many HIV/AIDS-related resources, including hotlines, publications and Web sites. They cannot, however, provide medical advice. Only qualified health care providers can answer personal medical questions.

The help line is sponsored by the National Institutes of Health, the Centers for Medicare and Medicaid Services, the Health Resources and Services Administration and the Centers for Disease Control and Prevention.

*For more information, go to <http://aidsinfo.nih.gov/>* ♦

#### Use of Rapid Oral HIV Test Extended

**O**n June 25, 2004, U.S. Department of Health and Human Services (HHS) Secretary Tommy G. Thompson announced that HHS has extended the availability of a recently approved rapid oral HIV test from the current 38,000 laboratories permitted to perform the test to more than 100,000 sites, including physician offices, HIV counseling centers and community health centers. In addition, Thompson announced that HHS would fund a \$4.8 million effort to add the rapid test to HHS-funded programs to reduce HIV/AIDS among injection drug users.

"These actions will expand even further the availability of a simple, rapid HIV test to communities where people are at high risk of HIV," Secretary Thompson said. "HIV testing has never been easier or more accessible than it is today."

To perform the oral test, the person being tested for HIV-1/2 takes the device, which has an exposed absorbent pad at one end, and places the pad above the teeth and against the outer gum. The person then gently swabs completely around the outer gums, both upper and lower, one time around. The device is then inserted into a vial containing a solution. The test device will indicate with more than 99 percent accuracy if HIV-1/2 antibodies are present in the solution by displaying two reddish-purple lines in a small window on the device.

Widespread availability of the rapid oral version of the HIV test will likely further increase overall HIV testing and decrease the number of people—an estimated 225,000 Americans—who are unaware they are infected with the HIV virus. Early testing enables infected individuals to obtain medical care earlier in the course of their infection, potentially saving lives and limiting the spread of this deadly virus.

*For more information on the rapid HIV test, call 888-463-6332 or go to <http://www.hhs.gov/news/press/2004pres/20040625b.html>* ♦

#### \$595 Million Awarded for AIDS Care in Urban Cities

**O**n March 1, 2004, U.S. Department of Health and Human Services Secretary Tommy G. Thompson announced the allocation of more than \$595 million to the cities hit hardest by the HIV/AIDS epidemic. The 51 grants will help these cities provide primary care and supportive services for low-income residents with HIV/AIDS.

"These grants will increase access to quality health care for those Americans living with HIV or AIDS, especially those who need help the most, including minorities, the uninsured and the underinsured," Secretary Thompson said.

The grants to 51 Eligible Metropolitan Areas (EMAs), which include both formula and supplemental grants, are funded under Title I of the Ryan White CARE (Comprehensive AIDS Resources Emergency) Act. Formula funds are awarded based on the estimated number of people living with AIDS in the city, and supplemental funds are awarded competitively among EMAs based on demonstration of severe need and other criteria. A portion of the grant awards will fund the Minority HIV/AIDS Initiative to bolster care and services among minority populations.

*For a complete list of cities and grant allocations, go to <http://www.hhs.gov/news/press/2004pres/20040301a.html>* ♦

# African Immigrants in the Spotlight

## *Minnesota Devises Strategies for Newest At-Risk Community*

Jennifer L. Rich

Several years ago, health workers in Minnesota started to notice an alarming trend. After years of relative stability or decline in new HIV infections in the African American community, the numbers started to rise again, particularly among women. The change was dramatic.

“We had been working with the African American community for a long time,” said Gloria Lewis, director of the Minnesota Office of Minority and Multicultural Health. “So when we saw the numbers we thought, ‘oh my God, what have we been doing wrong?’”

After combing through the epidemiological data, the Minnesota Department of Health came to a shocking conclusion. The jump could be attributed entirely to an increase in infections among African immigrants, who had been categorized as African American for statistical purposes. Indeed, while the African-born community in Minnesota accounted for only around one percent of the population, it represented 21 percent of all new infections in 2002. That’s 65 of the 305 new HIV diagnoses in the state that year.

Though Minnesota is the first state in the country to break out HIV/AIDS figures for African immigrants, states like New York and Washington also suspect that infection rates are high in their African-born communities. They point to the need for services specifically targeted to African immigrants in the United States.

Because of refugee and faith-based resettlement programs, Minnesota, and particularly the Minneapolis/St. Paul area, has experienced the fastest growth in its African-born population of anywhere in the country over the last 10 years. Most of these immigrants are from the East African countries of Somalia and Ethiopia, with smaller populations from Liberia, Kenya and Uganda.

Many of the social and cultural issues that contribute to the spread of HIV in Africa are also found in African communities here, starting with a basic lack of knowledge about reproductive health and HIV/AIDS transmission.

“In American communities, we know that HIV infection is about drug use or sex,” said Gwendolyn Velez, the executive director of the African American AIDS Task Force. “In African communities, transmission is often believed to come from other places, whether it is preordained from God, or other cultural beliefs.”

Lack of knowledge about the disease has created an environment of stigma and denial, according to the Minnesota Department of Health, which has conducted focus groups among African-born people in the state. Fear of being ostracized by family or community deters Africans from getting

tested or treated. Africans are often uncomfortable addressing any issues around HIV/AIDS, including sex.

“Cultural taboos around sex are still very much in place,” said Lucy Slater, the planning director of the STD and HIV section of the Minnesota Department of Health.

“We are finding that HIV-positive individuals rarely even talk to their sex partners about their status or about using protection.”

Getting Africans to seek treatment for HIV or AIDS is also a challenge, since they fear leaving clues of their infection, like frequent visits to the doctor or caseworker or a medicine cabinet full of pill bottles.

In an attempt to address some of the issues around HIV disease in the African community, the Minnesota Department of Health convened an HIV advisory group that represents the major African communities statewide. One of the first things the group decided, Slater said, is that they had to adopt new ways of thinking about HIV interventions.

“There is a culture around HIV prevention here that we just go in and tell it like it is,” Slater said. “But that is just not an approach that is going to be effective in the African community.”

She said that the advisory group is considering interventions that are modeled on health initiatives in Africa that aren’t related to HIV, such as vaccination campaigns.

“For vaccination campaigns, they send people into the community several weeks beforehand to talk to leaders and answer questions in the community in order to gain their confidence and trust,” she said. “So, by the time the people arrive with the actual vaccine, the community is prepared.”

Slater said that a recently successful intervention in the south of the state was a telling example. In the town of Mankato, a health worker spent an entire year working with the east African community to organize walking groups and cultural activities before she ever mentioned HIV. When she finally held an HIV intervention, it was well attended, but, Slater said, “It would never have happened if she hadn’t have spent a whole year there building trust.”

State and local organizations have also started sending African-born outreach workers to attend local community gatherings and work with leaders in African community agencies, churches and mosques. Community organizers are also testing the idea of using radio shows, plays and videos for HIV education purposes. In the Ethiopian Oromo community last year, a local organization developed a script, trained actors and delivered a performance about HIV in the local language. A second community-sponsored event included performances by a

drama troupe from South Africa. Both shows were popular.

In an effort to identify and test at-risk Africans, the African American AIDS Taskforce has collaborated with the Hennepin County Medical Center, one of the largest in the Minneapolis/St. Paul area, to have HIV educators and case workers inside the emergency walk-in clinic.

“Most of the African community uses the clinic as their primary source of healthcare, so we are able to reach them more effectively,” Velez said. “When you are out in the community, it is like a needle in a haystack.”

She said that much like a hospital would send in a nutritionist to talk to someone diagnosed with diabetes about a healthy diet, they send in an African-born outreach worker when patients are either diagnosed with an STD or appear to be at risk for HIV. Often, patients are convinced to get tested on the spot and are immediately provided with culturally sensitive case management services. Since the program began two years ago, Velez said the Taskforce staff has identified 17 HIV positive people, 15 of whom were African born.

Health workers across Minnesota stress that they are just beginning to make inroads into the African community. Needs assessments are still being done, and capacity building is a principal focus.

Capacity building in the African community is one of the key priorities of the Minnesota Office of Minority and Multicultural Health, according to Lewis.

“We’re building these agencies from the bottom up, but I think that we are making strides,” she said.

One priority is to make sure that outreach workers and case managers understand the language and culture of their clients. Equally important, however, is that service providers understand the intricacies of the health care and social service systems as well as the needs associated with recent immigration, such as housing, employment and legal paperwork.

The Minnesota Department of Health has also contracted the Red Cross to create a culturally and linguistically appropriate train-the-trainer program to increase the community’s capacity to educate itself.

Health experts in Minnesota say that they are fortunate to have highly educated and concerned members of the African community who are willing to get involved.

“The African leadership is really taking the lead to devise a solution for the community,” Velez said. “But we are starting from a different place, where we still need to work on breaking the silence. We have a lot of work to do.”

*For more information on the Minnesota Department of Health’s STD/HIV section and HIV/AIDS statistics, go to <http://www.health.state.mn.us> and click on Health and Statistics.* ♦

Rates and New Cases (per 100,000 persons) of HIV Infection by Race/Ethnicity & Mode of Exposure\* — Minnesota, 2002

Population	Rate	Cases
White, non-Hispanic	3.0	129
Black**, African American	37.0	62
Black**, African-born	130-185***	65
Hispanic	21.6	31
American Indian	8.6	7
Asian/PI	5.3	9
Unknown	---	2
Total	6.2	305

\* HIV infection includes all new cases of HIV infection (both HIV [non-AIDS] and AIDS at first diagnosis) among Minnesota residents in 2002.

\*\* African-born Blacks are reported separately from other Blacks (born in the U.S. or elsewhere).

\*\*\*Accurate population estimates for Black, African-born persons living in Minnesota are unavailable - anecdotal (50,000) and 2000 U.S. Census data (35,188) were used to create the range of rates reported for African-born persons. The population estimate for Black, African American persons (167,784) was calculated by subtracting the U.S. Census estimate for African-born persons (35,188) from the total Black population (202,972). Note that this assumes that all African-born persons are Black (as opposed to another race).

### Parents continued from 3

“Sex is a mystery to a lot of parents—to a lot of people—and there are a lot of venues around kids and parents that are trying to unveil that mystery and a lot of times parents are totally overwhelmed about the discussion about sex,” he said.

Faced with a question about sex, Austin said, parents tend to shut down because they don’t know what to say.

“But we are trying to convey to parents that they shouldn’t run away from that,” Austin said. “When a question comes up—what we call a teachable moment—parents need to slow down long enough to say, ok, I can actually deal with this question.”

To avoid telling people what to do, facilitators try to get the parents themselves to devise their own messages.

“I explain to parents that this is like a board: Nike has a board. VH1 has a board. All of those venues out there that are sharing information about sex with our children all have a group of people who sit around and craft the message,” Austin said. “And so the question we ask the parents is: ‘What message do you have?’”

He added: “When you have eight or nine mothers sitting around with 100-plus years of parenting experience among them, there is all kinds of information that they can share with each other. We tell them: ‘This is your board.’”

The “Board” concept also serves to create lasting relationships among group members, many of whom are raising children by themselves.

Austin says that the parents love the program because it provides them with the tools to be better parents.

Austin, who has four kids of his own, understands that feeling.

“I don’t want someone to unveil the mystery of sex for my kids,” he said. “I want to be able to have the skills and abilities to deal with this subject on a day-to-day basis regardless of how busy I am or how much is going on in my life.”

*For more information on the Parents Matter program, call 706-542-1806.* ♦

# Resources

## Center for AIDS Prevention Studies at the AIDS Research Institute

University of California, San Francisco  
74 New Montgomery, Suite 600  
San Francisco, CA 94105  
415-597-9100  
<http://www.caps.ucsf.edu>

## Centers for Disease Control and Prevention

National Prevention Information Network  
P. O. Box 6003  
Rockville, MD 20849-6003  
800-458-5231  
<http://www.cdcnpin.org>

## Maui AIDS Foundation

1935 Main Street, Suite 101  
P. O. Box 858  
Wailuku, Maui HI 96793  
<http://www.mauiaids.org>

## Minnesota Department of Health

Infectious Disease Epidemiology,  
Prevention and Control Division  
717 Delaware Street Southeast  
P. O. Box 9441  
Minneapolis, MN 55440-9441  
612-676-5414  
<http://www.health.state.mn.us/divs/idepc/stdhivsection.html>

## National Minority AIDS Council

1931 13th Street, N.W.  
Washington, DC 20009  
202-483-6622  
<http://www.nmac.org>

## National Women's Health Information Center

8550 Arlington Blvd., Suite 300  
Fairfax, VA 22031  
800-994-WOMAN  
<http://www.4woman.gov>

## New York Academy of Medicine

1216 Fifth Avenue  
New York, NY 10029  
212-822-7200  
<http://www.nyam.org>

## National Institutes of Health

Office of AIDS Research  
Building 2, Room 4E08  
Bethesda, MD 20892  
301-496-0357  
<http://www.nih.gov/od/oar/about/research/microbicides/oarmicro.htm>

## CDC Releases Asian-Language HIV/AIDS, STD Materials

### “HIV and AIDS: Are You at Risk?”

Explains HIV transmission and prevention methods; dispels myths; discusses testing and lists resources. Available in: Tagalog (SKU: E064), Khmer (SKU: E065), Vietnamese (SKU: E066), Korean (SKU: E067)

### “HIV and Pregnancy: Ten Things You Should Know: For You and Your Baby”

Explains risk behaviors associated with HIV transmission including ways to lower the risk of perinatal and neonatal transmission of HIV to infants. Available in: Chinese (SKU: E084), Vietnamese (SKU: E085),

### “Learn About HIV Testing”

Describes HIV testing and who needs to be tested; HIV testing is structured and what one should do if one tests positive. Available in: Khmer (SKU: E097), Vietnamese (SKU: E098), Korean (SKU: E100), Tagalog (SKU: E101)

### “Living with HIV/AIDS”

Provides an overview of the virus, as well as information on how to stay alive and healthy. Available in: Tagalog (SKU: E060), Khmer (SKU: E061), Vietnamese (SKU: E062), Korean (SKU: E063)

### “Teens and HIV and Other STDs: At Risk? Get Tested!”

Discusses testing for STDs and HIV; high risk behaviors; and other issues. Available in: Khmer (SKU: E087), Korean (SKU: E089), Tagalog (SKU: E090), Vietnamese (SKU: E091)

*Publications may be found by searching by their title, or by the SKU numbers provided.*

*Publications are also available in English and Spanish.*

*To order these and other HIV prevention materials, call 800-458-5231 or go to <http://www.cdcnpin.org> ♦*

## National Minority AIDS Council (NMAC) Organizational Effectiveness Series Now On CD-ROM

Not able to travel to technical assistance trainings? Now you don't have to.

To build the capacity of HIV prevention and care programs aimed at communities of color, the National Minority AIDS Council (NMAC) has released its entire Organizational Effectiveness series of 15 technical assistance manuals and CD-ROMs. Use them as do-it-yourself guides or in conjunction with NMAC recommendations and programs.

Funded by the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA), the series covers Board Development, Faith-based Leadership Development, Fiscal Management, Grant Writing, HIV Prevention Community Planning, Human Resources, Leadership Development, Needs Assessment, Program Development, Program Evaluation, Starting a Nonprofit, Strategic Planning, Surviving an Audit, Technology Development and Volunteer Management.

To order a copy of the series, call NMAC at 202-234-5120 or e-mail [ta\\_info@nmac.org](mailto:ta_info@nmac.org). The series can also be downloaded from the NMAC Web site at <http://www.nmac.org>. Click “publications,” then “TA publications.” The manuals and CD-ROMS will be available in Spanish later in 2004. ♦

“Ella decía que su mamá estaba siempre trabajando, siempre ocupada”.

Para paliar la situación, un segmento del curriculum les pide a las madres que definan metas para crear tiempo para hablar a solas con sus hijas.

El curriculum también incluye una sección sobre promover conversación. En lugar de elementos que imposibilitan la comunicación, como “Tú no puedes tener novio hasta los 21”, se instruyó a las madres para que suavizaran el lenguaje: “Aunque yo preferiría que tú esperaras, si tú decides tener un novio, yo prefiero saberlo”.

Como parte de un ejercicio sobre relaciones intergeneracionales, se les pidió a las mujeres que explorasen los sentimientos de sus familias con respecto a asuntos sexuales.

Según Martínez, el mensaje fue: “Nosotros definitivamente queremos conservar nuestras tradiciones, pero ¿vamos a conservar la tradición que dice que no podemos hablar de sexual y salud sexual? ¿Realmente queremos pasar estos valores a nuestras hijas?”

En la tercera sesión, las mujeres tuvieron una sesión de conversación privada sobre sus retos y factores de riesgo particulares, en las cuales se les presentó información específica sobre el aumento de las infecciones de VIH entre latinas.

“Muchas mujeres están preocupadas sobre la infidelidad, pero no usan protección”, dijo Martínez.

Para abordar sus preocupaciones, el equipo dedicó un segmento al uso correcto del preservativo o condón.

Al final, el curriculum del seminario fue elogiado por todas las participantes en una encuesta posterior al estudio, según Martínez. La encuesta también mostraba incrementó significativamente su nivel de conocimiento y mejoró sus habilidades de comunicación con sus hijas. Las mujeres también comenzaron a provocar conversaciones con sus hijas que no habrían ocurrido antes del programa.

Y, lo más importante, Gómez dijo, las mujeres incrementaron la percepción de su propio riesgo.

“Seguimos asumiendo que la información ya está disponible”, dijo Gómez. “Mientras seguimos viendo incrementos en nuevos casos de VIH y la rampante epidemia de ETS, particularmente entre las minorías, no podemos olvidar que hay algunos problemas básicos de conocimiento y alfabetización en eso”.

Gómez y su equipo están escribiendo sus descubrimientos para publicación y están buscando financiamiento para realizar un estudio clínico completo que podría incluir algún día comunicación madre a hijo.

Por el momento, ellos han estado presentando el programa a diferentes públicos en el país, con alentadores resultados.

“Lo destacable es el número de comunidades en todo el país—rurales, urbanas, en la región central, en la costa—donde las personas estaban realmente entusiasmada con esto”, dijo Gómez. “Ellos pensaban que realmente podría ser puesto en práctica en sus comunidades. Dijeron que traspasa fronteras étnicas”.

La idea más interesante, dijo ella, fue de un grupo en Memphis que pensaron que el programa sería excelente para las abuelas afroamericanas quienes están criando a sus nietos adolescentes.

Para más información sobre el curriculum *De madre a hija* (From Mother to Daughter), llame al CAPS al 415-597-9230. ♦

to keep our traditions, but are we going to keep the tradition that says that we can't talk about sex and sexual health? Do we really want to keep passing these values on to our daughters?”

In the third session, women came in for a private talk about their own challenges and risk factors, where they were presented with specific data on the increase in HIV infections among Latinas.

“A lot of the women are worried about infidelity, but they don't use protection,” Martinez said.

To address their concerns, the team dedicated a segment to proper condom use.

In the end, the curriculum was universally praised by the participants in a post-study survey, according to Martinez. The survey also showed that the initiative significantly increased their level of knowledge and improved their communication skills with their daughters. The women also began to initiate conversations with their daughters that they wouldn't have had before the program.

And most importantly, Gómez said, the women had an increase in their own perceived risk.

“We keep making the assumption that the information is already out there,” Gómez said. “As we start to see increases in new cases of HIV and the rampant epidemics of STDs, particularly among the minority populations, we can't forget that there are some basic knowledge and literacy issues here.”

Gómez and her team are writing up their findings for publication and are searching for funding to do a full clinical trial that may someday include mother-to-son communication.

In the meantime, they have been presenting the program to audiences around the country, to heartening results.

“What is remarkable is the number of communities all over the country—rural, urban, in the middle, on the coast—where folks were really excited about it,” Gómez said. “They thought it could really be implemented in their communities. They said that it goes across ethnic boundaries.”

The most interesting idea, she said, was from a group in Memphis who thought that the program would be great for African American grandmothers who are raising their adolescent grandchildren.

For more information on the *From Mother to Daughter* curriculum, call the Center for AIDS Prevention Studies at 415-597-9230, or go to <http://www.ucsf.caps.edu> ♦

**DEPARTMENT OF HEALTH & HUMAN SERVICES**

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Office of Minority Health Resource Center  
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## Conferences

### September 21, 2004

Join us in encouraging those most in need of health care to visit a doctor during the third annual *Take A Loved One to the Doctor Day*. Regular health screenings are a critical step to a healthier U.S.

To learn how you can help make this year's *Take A Loved One to the Doctor Day* the most successful yet, visit our Web site at <http://www.omhrc.gov/healthgap/index.htm> or give us a call at 800-444-6472.

### October 21-24, 2004

#### United States Conference on AIDS

Philadelphia Marriott Hotel, Philadelphia, PA  
Contact: National Minority AIDS Council  
202-483-6622  
<http://www.nmac.org/>

## Consider the Benefits to Your CBO...

### *The Resource Persons Network !*

Professional volunteers ♦ Minority health experts  
Program development ♦ Grant reviewers  
Capacity building ♦ Technical assistance



Resource Persons Network  
Connecting with Communities

To learn more about this free service,  
please visit the Office of Minority Health Resource Center at  
<http://www.omhrc.gov> or call 800-444-6472 ext. 277.

The Office of Minority Health Resource Center is a nationwide service of the  
U.S. Department of Health and Human Services.

