

Why we can't wait:

The Tipping Point for HIV/AIDS Among African Americans

African American Perspectives
and Recommendations for
State and Local AIDS Directors
and Health Departments

Why we can't wait:

"NASTAD, as the unified voice of U.S. state and territorial AIDS directors, is committed to this enormous challenge. We continue ever-vigilant in the fight against HIV/AIDS, bringing greater attention and focus to the unacceptable disparities in HIV/AIDS in African American communities across the country."

Julie M. Scofield
NASTAD Executive Director

Table of Contents

- Executive Summary** 3
- Introduction** 6
- Key Issues and Successful Strategies** 9
 - An Epidemiological Perspective on HIV/AIDS in African American Communities** 9
 - A Successful Strategy from Michigan 15
 - Capacity Building** 17
 - A Successful Strategy from New York 19
 - Coalition and Partnership Building** 21
 - A Successful Strategy from Maryland 23
 - Program Implementation** 25
 - A Successful Strategy from Wisconsin 28
 - Behavioral Research** 30
 - A Successful Strategy from Illinois 33
- Appendices** 35
 - Appendix 1:** Comprehensive List of Recommendations 35
 - Appendix 2:** Health Department Self-Assessment Tool 41
 - Appendix 3:** Other Successful Strategies 45
 - California 45
 - Florida 47
 - Illinois 50
 - Louisiana 52
 - Maryland (2) 54
 - Minnesota 58
 - Nebraska 61
 - New Jersey 63
 - North Carolina 65
 - Appendix 4:** Sample Job Description for Minority AIDS Coordinator Position (2) 67
- References** 69

Why we can't wait:

Executive Summary

In 2001, the National Alliance of State and Territorial AIDS Directors (NASTAD) released the monograph, *HIV/AIDS: African American Perspectives and Recommendations for State and Local AIDS Directors and Health Departments*. The intent of the document was to increase synergy between the public health system and African American communities in order to halt the devastation of HIV/AIDS. Since the release of the 2001 monograph, many state and local health departments further responded to the AIDS crisis in African American communities by allocating additional funding, designing and implementing innovative programming, and dedicating staff and other resources to confront the crisis. Unfortunately, these and other efforts have not proven entirely successful in decreasing national rates of new HIV infections among African Americans.

In epidemiology, the term 'tipping point' characterizes the point at which an epidemic reaches critical mass, when a seemingly rare outbreak has proliferated into a legitimate public-health crisis. HIV/AIDS tipped many years ago and has since had a devastating impact on African American communities. This monograph hopes to catalyze a second tipping point, a time when all efforts in the fight against HIV/AIDS begin to come together to create a meaningful and unified response that ultimately reduces new infections and ensures access to quality care and treatment for individuals living with HIV/AIDS.

In response to this growing epidemic, NASTAD updated its strategic map in 2006 to reflect a renewed and focused approach to addressing the HIV epidemic in communities of color. Consistent with the updated strategic map, the ever-changing political landscape, and the advent of new technologies, NASTAD is releasing this updated version of its 2001 monograph. The revised monograph—*Why We Can't Wait: The Tipping Point for HIV/AIDS in African American Communities*—seeks

to further heighten the response to HIV/AIDS in the African American community by calling for coordinated and decisive action from health departments and the communities they serve. In epidemiology, the term 'tipping point' characterizes the point at which an epidemic reaches critical mass, when a seemingly rare outbreak has proliferated into a legitimate public-health crisis. HIV/AIDS tipped many years ago and has since had a devastating impact on African American communities. This monograph hopes to catalyze a second tipping point, a time when all efforts in the fight against HIV/AIDS begin to come together to create a meaningful and unified response that ultimately reduces new infections and ensures access to quality care and treatment for individuals living with HIV/AIDS.

Opinions vary as to the primary reasons this epidemic continues to ravage African American communities. Research suggests that issues like the lack of quality health care, inadequate education, poverty, and lack of substantive empirical research on the various conditions that advance disease proliferation and progression, among other factors, all contribute to the sustained impact on African Americans. The U.S. Department of Health and Human Services (HHS) initiative, *Healthy People 2010*, states explicitly that "inequalities in income and education underlie many health disparities in the United States" and that a multidisciplinary approach is necessary to reduce or eliminate these disparities.¹ Based on the tipping point concept, small advances in any or all of these areas can potentially result in large effects and positive change for African American communities. This updated edition of the 2001 monograph intends to advance this theory through presentation of perspectives, questions, potential remedies, and strategies, each of which may create the necessary momentum to have a legitimate impact on rates of HIV/AIDS infection in African American communities.

As with the 2001 document, this revised monograph is designed to encourage state and local AIDS directors to continue enhancing their work, refining promising approaches, and investigating new methodologies and models. Additionally, the monograph reiterates certain sociocultural factors, considers new factors, and describes how these factors conspire to undermine

even the best efforts of health departments working to reduce HIV infections among African Americans. The importance of sociocultural factors such as historical underpinnings, cultural norms, external factors (e.g., poverty and racism), and access barriers cannot be overstated.

This updated monograph also aims to assist AIDS directors in developing collaborations with African American communities to more effectively advocate on their behalf. To achieve this purpose, the updated monograph:

- **Examines the Sociocultural Factors that Affect HIV/AIDS Among African Americans**

This document examines the sociocultural factors that contribute to the HIV/AIDS epidemic among African American communities. Using these factors as a framework, state and local health departments can help appropriately shape future responses and programs to address the crisis.

- **Revisits Key Issues**

This monograph explores key issues in the areas of epidemiology, capacity building, coalition and partnership building, program implementation, and behavioral research that are specific to the African American experience.

- **Provides Recommendations**

This document builds on the recommendations put forth in the 2001 monograph. NASTAD's African American Advisory Committee prioritized the 2001 recommendations, selecting those they believe need increased emphasis on the part of state and local health departments. Enhancement of these prioritized recommendations will provide specific steps and resources for improving the quantity and quality of HIV/AIDS prevention and care services for African American communities.

- **Acts as a Springboard for Discussion and Action**

NASTAD and its African American Advisory Committee want this monograph to serve as a springboard for pivotal discussions between African American communities, health departments, and national leaders.

A national response to the epidemic among African Americans recognizes the central role of state health departments in HIV/AIDS prevention and care service delivery. Public health agencies are the first line of defense for HIV/AIDS programming targeting African Americans and other communities. Furthermore, state

public health agencies are entrusted through U.S. law to be the "central authorities of the nation's public health system" and, as such, bear primary public sector responsibility for the health of their communities.² Therefore, state and local health departments are key partners and leaders in this heightened response to fighting HIV/AIDS in African American communities.

Public health agencies are the first line of defense for HIV/AIDS programming targeting African Americans and other communities.

Using the framework outlined above, we can begin to critically explore the public health response to HIV/AIDS for African Americans and examine the relationship between African Americans and public health. To effectively lead, health departments must give voice to topics that have historically been avoided and unaddressed. Understanding the underlying sociocultural factors, like systematic and generational trauma and stigma, can help AIDS directors shape, develop, and implement sound programs to combat HIV/AIDS among African Americans in their jurisdictions.

Health departments must also provide proactive opportunities for leadership development by prioritizing internal support mechanisms that efficiently prepare their staff to address this crisis. Key strategies include provision of professional development and resources and training programs to foster leadership among African American staff and community stakeholders. This is an important step that AIDS directors must take to fulfill their leadership mandate of preventing and treating HIV/AIDS in African American communities.

The original monograph included recommendations for state and local health departments to address the challenges of HIV/AIDS in African American communities. **In 2007, NASTAD's African American Advisory Committee reviewed those recommendations and prioritized those that can yield the most robust response in mitigating the epidemic among African Americans.** The prioritized recommendations are examined further within each of the five key issue areas:

- Usage and Interpretation of Epidemiological Data

The Tipping Point for HIV/AIDS Among African Americans

- Capacity Building
- Coalition and Partnership Building
- Program Implementation
- Behavioral Research

Where appropriate, “new considerations” are also presented under the five key issue areas. The new considerations represent knowledge that has been gained since the release of the 2001 monograph. While

these new considerations exist outside the bounds of the 2001 recommendations, they are essential to health departments’ ongoing work to combat HIV/AIDS in African American communities.

The revised document is also intended to be used as a tool to foster stronger linkages between health departments, African American organizations, and with African Americans living with or affected by HIV/AIDS.

Introduction

In 2001, NASTAD's African American Advisory Committee (AAAC), comprised of African American HIV/AIDS directors and program staff from state and local health departments, along with NASTAD's Executive Committee (EC), determined that health departments must make an unwavering commitment to addressing the HIV/AIDS crisis among African Americans. This determination led to the development and release of a monograph, *HIV/AIDS: African American Perspectives and Recommendations for State and Local AIDS Directors and Health Departments*. Although much has changed in the ever-growing AIDS epidemic, much has remained constant within African American communities. Over the past 25 years, the public health community made significant strides in addressing the HIV/AIDS epidemic. Yet, despite widespread discussion about the epidemic and some measurable progress in key areas, the overall impact in African American communities has been negligible.³ African Americans currently represent more than half of all HIV/AIDS cases in the U.S..⁴ The continued trajectory of HIV infection among African Americans clearly points to a community in crisis.

Why We Can't Wait: The Tipping Point for HIV/AIDS in African American Communities is designed to enhance public health officials' ability to cultivate a deeper understanding of the needs and concerns of African Americans and to strengthen collaboration with African American communities. The updated document acknowledges the shifting landscape of HIV/AIDS and its implications for work that must be done. This document also details the work of several jurisdictions that effectively used a number of the recommended strategies and techniques outlined in the 2001 monograph. This work is presented in the updated monograph as "successful strategies," which include community meetings and forums, internal action planning, large-scale collaboration with community stakeholders, and specially-designed programs and initiatives.

Purpose

The original monograph was developed as a resource to assist state and local AIDS directors in enhancing their response to the local, regional, and national HIV/AIDS crises in African American communities.⁵ To

further support this purpose, the revised monograph acknowledges significant events and changes made within the past five years in HIV/AIDS prevention and treatment, while examining the historic underpinnings that continue to affect HIV/AIDS among African Americans. An added feature of the updated monograph is the pairing of the five key issue areas with successful strategies that highlight best practices from various jurisdictions.

Way Forward

The disparities in African Americans' health and wellness in the U.S. and the daunting impact of HIV/AIDS cannot be questioned or disputed today. Statistics and other major indicators point to a community in crisis. Upon deeper consideration, the following questions emerge:

- Who is responsible for addressing the challenges that precipitated the spread of HIV/AIDS in the Black community?
- What is the responsibility of African Americans themselves?
- What is the responsibility of church and faith communities?
- What is the responsibility of the public health system in this country?
- What is the responsibility of AIDS directors and health departments throughout the 65 jurisdictions within the U.S.?
- What is the responsibility of national and civic institutions, business, civic leaders, and society as a whole?

Since the 2001 monograph was published, definitive data are still lacking about why African Americans are becoming infected with HIV and progressing to AIDS at such alarming rates. This points to the growing need for a comprehensive research agenda that emphasizes the influence of sexual identity, race, and discrimination on HIV infection and health-seeking behaviors.

Moreover, socio-economic status and cultural factors pose a special set of concerns for African Americans and can result in the following:

- A deep mistrust of the public health

system originating from historical events such as the Tuskegee Syphilis Study;

- A lack of well-funded, culturally-specific interventions which increases the conventional wisdom of many African Americans and their sense of alienation from a system they already do not trust;
- A lack of culturally-competent HIV prevention, care, and treatment services;
- Low health-care seeking behaviors related to mistrust of the public health system, lack of health insurance, and lack of culturally-competent health service providers;
- Stigmatization within African American communities which keeps men who have sex with men (MSM), women, and injection drug users from accessing care; and
- High rates of poverty, unemployment, and underemployment which adversely affect health outcomes.

In light of these co-factors, there is promising news. First, the development of new drug therapies is making HIV infection and AIDS increasingly more manageable. Second, there is a resurgence of broad-based activism along with invigorated political, intellectual, and religious leadership. Additionally, advancements in new HIV prevention strategies, including pre- and post-exposure prophylaxis, and the role of potential precipitators, such as a lack of circumcision and concurrent sexual partnerships, are being recognized and investigated. Finally, public interest in meaningful bio-medical research, including development of a vaccine and microbicides, as well as other treatment advances for persons living with HIV/AIDS, is gaining increased support. Amid these developments, public health officials must continue to take thoughtful, prudent action to intervene by implementing successful and effective HIV prevention and care programs. This updated monograph profiles many “successful strategies” that health departments have implemented in each of the key issue areas, demonstrating forward movement on these important issues since 2001.

Future guiding principles for HIV/AIDS programs targeting African Americans must involve creative and successful solutions that offer holistic, comprehensive,

and collaborative engagements among stakeholders. The barriers that have impeded progress must be addressed, including those linked to popular and political culture (e.g., the media and broad-based popular opinion), stigma and discrimination, inadequate definitions of high-risk groups, the overtaking of public health HIV/AIDS programs, and the need for higher prioritization of HIV/AIDS within African American communities. Given these barriers, there are myriad perspectives, questions, and potential remedies presented in this revised monograph.

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We all must ask ourselves: *Can this country witness an unprecedented turn for the better in the state of HIV/AIDS among African Americans, a tipping point, before the decade is over?*

Philosophical Principles of Engagement and Support

The cultural, spiritual, and psychological nature of African American people necessitates a set of principles of engagement and support that are grounded in practicality while allowing room for creativity and flexibility in service delivery. The following principles are recommended for health departments and collaborative partners to champion the way forward and create the tipping point within African American communities:

- Require innovative and creative response mechanisms that are considerate of the social determinants that affect the lives of African American people (e.g., social networks, access to resources, racial discrimination, and income levels);
- Underscore a responsibility and accountability at all levels to promote a shared engagement by African American communities;

- Approach African American communities from a holistic perspective, affirming values of self-determination, as well as racial and ethnic pride;
- Support and seek resources at the local, state, and national levels as imperatives for strategy development and deployment;
- Address the unique perspectives and needs of high-risk segments of the African American community, particularly MSM, heterosexual women, youth, and incarcerated individuals; and
- Proactively address and challenge stigma, fatalism, and denial of HIV/AIDS in African American communities.

Health Department Leadership

Competency and innovation led by health department leadership must become the cornerstone for future responses. The updated monograph offers concrete steps that AIDS directors can take to address the challenges associated with combating HIV/AIDS in African American communities. In addition, AIDS

directors should become more aware of how they currently view the different populations in their jurisdictions and how their views impact the delivery of services. The revised monograph can also assist AIDS directors in bridging science, policy, and public health imperatives on behalf of African American communities with a provocative and proactive focus based on clear action steps rather than abstract thinking. Success is predicated on effective dialogue and information sharing between senior public health leadership, mid-level staff, and the community.

Summary

NASTAD's African American Advisory Committee and Executive Committee contend that there is a need to continue to address the HIV/AIDS epidemic in African American communities with deliberate speed and efficacy. *Why We Can't Wait: The Tipping Point for HIV/AIDS in African American Communities* serves as a call to every health department and every American to pledge—in solidarity—to face HIV/AIDS head-on in order to decrease the devastating impact on African American communities.

Key Issues: **An Epidemiological Perspective on HIV/AIDS in African American Communities**

“Regional statistics for infection rates among African Americans rival those in developing countries whose national identities have become indistinguishable from this global epidemic.”³

Since NASTAD released its 2001 monograph, the HIV/AIDS epidemic has remained an ongoing crisis in African American communities. Dr. Lorraine Cole, president and CEO of the Black Women’s Health Imperative, referred to the present impact of HIV/AIDS on African American women as “a disease of mass destruction.”³ For African American men and women across the U.S., HIV/AIDS continues to have a devastating impact.

The study of epidemiological data provides compelling evidence for this devastating, and disproportionate, impact on African American communities. HIV/AIDS data help health departments and communities describe the similarities and differences in the way HIV/AIDS manifests in different groups and locations. However, epidemiological data can be difficult to use and challenging to understand. A lack of understanding of how to translate data at the local, state, and national level is a major barrier to using the data in decision-making. Furthermore, terminology and scientific information can be confusing and difficult to understand without the expertise of trained epidemiologists. Because some health departments may not thoroughly understand the data, their ability to analyze it and subsequently develop effective programs based on it may be compromised.

While this section highlights the real importance of epidemiological data in the development of responsive HIV/AIDS programming, it also challenges AIDS directors, their staff, and the communities they serve to understand and acknowledge the limitations of these data and to consider new ways of looking at the impact on African American communities. In order to ensure that funding is allocated appropriately based both on epidemiological evidence and other importance evidence, AIDS directors must continue to engage in

informed decision making that is justifiable, meaningful, and theoretically-sound.

Profile of HIV/AIDS Cases among African Americans

This section presents a brief profile of the epidemic in the U.S. Because some states and territories do not yet report confidential name-based HIV infection data, both HIV and AIDS case data will be presented to provide a more comprehensive picture of the impact of HIV/AIDS on African American communities.

At the end of 2005, more than 476,000 people were living with HIV/AIDS (in 33 states with confidential name reporting in the U.S.).⁶ The prevalence of HIV (not AIDS) and AIDS was 515 and 639 per 100,000, respectively.⁷ African Americans comprised more than 47 percent of living HIV/AIDS cases at the end of 2005 and whites nearly 34 percent.⁶ However, when compared to the percent of the population in the U.S., HIV/AIDS are disproportionately affecting minority populations – only 13 percent of the U.S. population are African American, while 72 percent are white.^{7,8} Adult/adolescent African American males made up almost 29 percent, or one in three, of all living HIV/AIDS cases and 62 percent of cases among African Americans.⁶ Forty-eight percent of adult/adolescent African American males living with HIV/AIDS were infected through sex with other men, 23 percent through injection drug use and 22 percent through heterosexual contact.⁶ Adult/adolescent African American females made up more than 17 percent of all living HIV/AIDS cases and approximately 36 percent of cases among African Americans.⁶ Seventy-four percent of adult/adolescent African American females living with HIV/AIDS were infected through heterosexual contact and 24 percent through injection drug use.⁶ While perinatal HIV/AIDS cases represented only one percent

(6,109 cases) of the total living HIV/AIDS cases at the end of 2005, cases among African Americans (4,008 cases) were nearly three times greater than cases among Hispanics (1,214 cases) and five times greater than among whites (800 cases).⁶

While the estimated number of diagnosed HIV/AIDS cases in the 33 states with confidential name reporting has remained relatively stable since 2001, African Americans remained disproportionately impacted, representing approximately 50 percent, or one in two, of all diagnosed HIV/AIDS cases each year.⁶ Of HIV cases diagnosed in 2005, the most recent year for which national data are available, 40 percent of African Americans were also diagnosed with AIDS within a year of their HIV diagnosis, nearly two cases in five.⁶ Individuals who, at the time of HIV diagnosis, are concurrently diagnosed with AIDS or progress quickly to AIDS represent a serious concern for both HIV prevention and care and treatment services.

In 2005, there were an estimated 44,198 AIDS cases in the 50 states and the District of Columbia, a rate of 14.9 per 100,000 in the general population.⁶ African Americans comprised 50 percent of AIDS cases in 2005, a rate of 59 per 100,000, whites nearly 29 percent, a rate of 6.3 per 100,000, and Hispanics, 19 percent, a rate of 19.8 per 100,000.⁶ Adult/adolescent African American males made up 32 percent, or one in three, of all AIDS cases in 2005, a rate of 103.6 per 100,000.⁶ Adult/adolescent African American females made up almost 18 percent of all living HIV/AIDS cases, a rate of 49.9 per 100,000.⁶

Interpretation

NASTAD and the African American Advisory Committee continue to recognize the critical role of epidemiology in analyzing, understanding, and explaining the domestic HIV/AIDS epidemic. Public health programs continue to use epidemiological data to justify the provision of services for the prevention of disease and maintenance of health. Epidemiological information can be effectively used to gain the attention and support of leaders, policy makers, service providers, and the community at large. It also serves as a major conduit to assist health departments and organizations in the development of programs and allocation of funding based on current epidemiological trends, as well as social and empirical research.

However, the domain of epidemiology and vital statistics can prove to be a double-edged sword. The use of epidemiological information can be a source of

threat and serve as a detriment if it is misunderstood, misinterpreted, and/or misrepresented. In some cases, such data have been used to dictate decisions that serve neither the best interests of African Americans nor the HIV prevention and treatment services designed for this target population. AIDS organizations, the media, and the public may also misinterpret data with the disastrous results of increasing the stigma and shame for individuals.

Interpretations of Epidemiological Data Can Be Stigmatizing

Undoubtedly, stigma is a barrier that discourages individuals from obtaining prevention information and treatment for HIV/AIDS because of fear of being ostracized by the larger community.¹⁷ Moreover, HIV/AIDS epidemiological information can unintentionally stigmatize, alienate, and pathologize African Americans. Addressing the role of stigma among African American communities is critical; however doing so without explaining a broader context can reinforce or heighten stigma associated with homosexuality, injection drug use, and various other behaviors negatively labeled by the larger community. One example of this is associating the rising rates of HIV infection among African American women with the same-sex behavior of their male sex partners, thereby placing blame and further ostracizing gay and bisexual men. This results in discouraging African American men, seen as “vectors of disease,” and African American women, seen as “unempowered,” from engaging in meaningful discussions about how to prevent the transmission of HIV.

These cycles of blame and stigmatization are counterproductive to the positive programs that health departments are implementing to prevent the spread of HIV. AIDS directors and health departments should be aware of the potential ramifications of epidemiological data interpretation and analysis and endeavor to present information in a way that encourages everyone to be valued for their worth as a human being. Furthermore, collaboration with health advocates and non-traditional stakeholders may serve fruitful as their understanding of community norms and culture is an integral partner to epidemiological data.

Ways to Combat Stigmatizing Interpretations of Epidemiological Data

AIDS directors and health departments should conduct thorough analyses when examining the research findings related to African American communities and not merely accept the epidemiological data at face value. Misinterpretations of data can be avoided if efforts are

made to understand the environment in which data are presented. Recommendations in this section in 2001 provided steps to contextualize epidemiological presentations to avoid misinterpretation and unintended stigmatization. This updated version encourages health departments to conduct a self-assessment utilizing the tool containing the three primary recommendations for this section (see Appendix 2).

New Considerations

While HIV/AIDS cases across the U.S. share common features, the study of their unique characteristics illustrates important differences between affected groups and must be understood by health departments as they act to stop the spread of disease. In the U.S., the HIV/AIDS “epidemic” is generally referenced as a single homogeneous entity, perhaps because the epidemic unfolded two-and-a-half decades ago in a largely concentrated population—white gay men. However, as the virus became more evident in African American communities, the manner by which the epidemic is described, referenced, and treated has not changed. As a result, policies, interventions, activities, and funding dedicated to preventing new infections have long been framed in response to the idea of a singular epidemic. The different and distinct characteristics of a possible epidemic among African American communities, or particular sub-sets, may, therefore, not be fully understood. Historically, as seroprevalence rates have increased and decreased, the “epidemic” is said to have evolved and changed. There has yet to be pronounced consideration of the possibility of co-occurring epidemics in the U.S., specifically an epidemic that affects African American communities, or particular sub-sets, in different ways.

While epidemiological data clearly demonstrate the disproportionate impact of HIV/AIDS on African American communities, when aggregated into a single “epidemic,” they do not offer a nuanced understanding of how HIV/AIDS actually manifests within African American communities. Instead, strict rules of interpretation are followed in order to make accurate comparisons between African Americans and other groups. While using strict interpretation preserves the integrity of the data, it also, limits the breadth of the usefulness of HIV/AIDS data.

In the U.S., the HIV/AIDS “epidemic” has been characterized as concentrated in specific groups within the general population. The groups are defined as “high-risk” for HIV infection due to specific sexual and drug

using behaviors, like sex with high-risk partners and injection drug use. However, looking beyond “high-risk” behavior may compliment traditional epidemiological data and help to illuminate important factors that can potentially better describe the impact of HIV/AIDS among African Americans. When the context of behavior is taken into consideration, the impact of HIV/AIDS may be notably different for African Americans, or specific sub-sets, than for others groups.

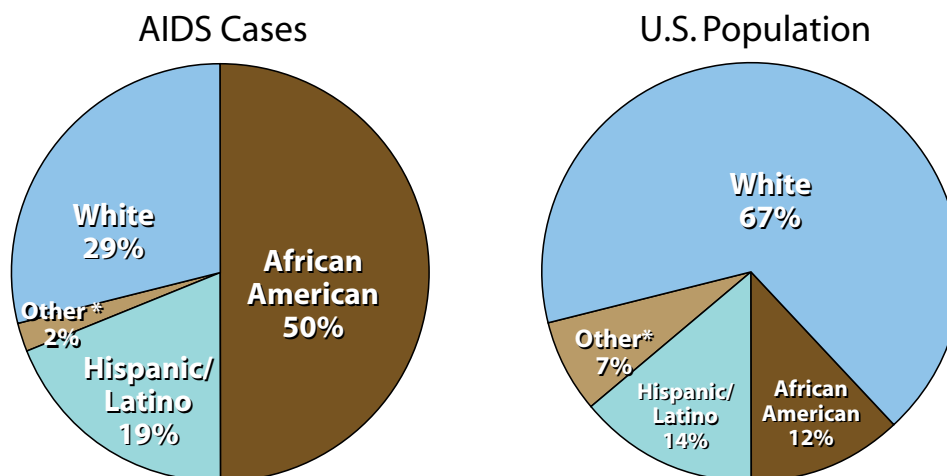
Research has been published recently that challenges the notion of the HIV/AIDS epidemic as currently understood. In the January 2007 edition of the *American Journal of Public Health*, researchers present findings from research specifically designed to examine whether individual sex and drug using behaviors account for racial disparities in HIV and STD prevalence.¹⁸ Using data derived from the *National Longitudinal Study of Adolescent Health*, the researchers analyzed behavior patterns based on participants’ sex and drug use responses and compared STD/HIV prevalence for these patterns by race. Their research revealed that STD/HIV infection rates were much higher for African Americans than for whites. More importantly their research indicated that, among African Americans, individual behavior may be of limited utility in understanding risk for HIV. Among white young adults, STD/HIV prevalence was higher than the overall population prevalence only among those individuals reporting high-risk behaviors such as male-male sex and injection drug use. By contrast, the prevalence rate among African American young adults was substantially higher than the overall population prevalence regardless of risk. In other words, African Americans who reported behaviors traditionally considered low risk were nearly as likely as those who reported high-risk behaviors to be infected with an STD or HIV.

Epidemiological data offer a way to understand the impact of HIV/AIDS on African American communities in broadly defined groupings, like race/ethnic and behavioral risk groups. While this analysis is essential, its simplicity may rule out the consideration of other nuances that are more meaningful in funding decisions and the development of programs and policy. Focusing on a single epidemic within the U.S. may overlook the actual proliferation of disease with African American communities, or specific sub-sets. If African Americans are at risk for HIV infection at rates much higher than other racial and ethnic groups and, at the same time, are at risk despite any specific risk behavior, great implications exist for HIV prevention and care and treatment services targeting this population.

General Statistics

- African Americans currently represent more than half of all HIV/AIDS cases.⁶
- In 2005, African American men are diagnosed with HIV/AIDS at a rate seven times higher than that of white men.⁹
- CDC data suggest that African Americans tend to be diagnosed with HIV infection much later and often at a more advanced stage of their illnesses.¹⁰
- African Americans die from AIDS-related complications sooner than any other racial/ethnic group in the U.S.¹⁰
- In 2005, an estimated 19,000 young people between the ages of 13 and 24 were living with HIV/AIDS – 61 percent were African American.⁶
- African Americans and other minorities are more likely to be uninsured and, therefore, less likely to receive timely preventive care.¹¹
- According to the Institute of Medicine (IOM), several reports indicate that African Americans and other racial/ethnic minorities may receive lower quality healthcare and treatment, regardless of their insurance status.¹²

Figure 1
Estimated AIDS Diagnoses & U.S. Population by Race/Ethnicity, 2005



*Other includes Asian/Pacific Islanders, Alaskan Natives, and Native Americans as well as those of two or more races.

1 CDC, *HIV/AIDS Surveillance Report*, Vol. 17; 2006.

2 Calculations based only on cases for which race/ethnicity data were provided.

3 U.S. Census Bureau, 2005 Population Estimates.

African American Women

- In 2005, African American women in the U.S. were diagnosed with HIV/AIDS at a rate 21 times that of white women.⁷
- HIV/AIDS is now the leading cause of death for African American women ages 25-34.⁹
- At the end of 2004, more than 64 percent (79,170) of the estimated 123,405 women living with HIV/AIDS were African American.¹³
- For young African American women (ages 20-24), HIV infection has been cited as one of the four leading causes of death.¹⁴

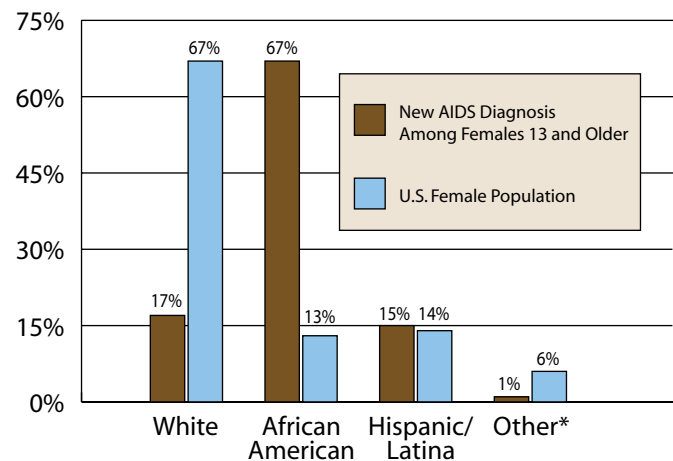
African American Men who have Sex with Men (MSM)

- A study of MSM conducted in five U.S. cities (Baltimore, Los Angeles, Miami, New York City, and San Francisco) from June 2004 to April 2005, showed that 46 percent of Black MSM tested were HIV-positive, and 67 percent of these men were unaware of their status.¹⁵

The Incarcerated Population

- According to the U.S. Department of Justice, among male inmates, African Americans were nearly twice as likely as whites to be HIV positive and the rate of HIV infection among white female inmates was nearly half that of African American female inmates.¹⁶
- African American inmates were twice as likely as Hispanics and two-and-a-half times more likely than whites to die from AIDS-related causes.¹⁶
- In 2002, AIDS-related deaths among African American inmates accounted for two-thirds of all AIDS-related deaths.¹⁶

Figure 2
Estimated New Female AIDS Diagnoses & U.S. Female Population by Race/Ethnicity, 2004



*Other includes Asian/Pacific Islander, Alaskan Native, and Native American women as well as those of two or more races.

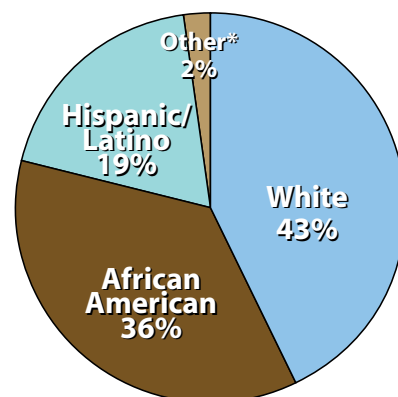
1 CDC, *HIV/AIDS Surveillance Report*, Vol. 16; 2005.

2 Kaiser Family Foundation analysis of Urban Institute estimates of March 2005 Current Population Survey, U.S. Bureau of the Census.

3 Estimates do not include cases from the U.S. dependencies, possessions, and associated nations, and cases of unknown residence.

Figure 3
Race/Ethnicity of MSM with HIV/AIDS diagnosed during 2001-2004

MSM (n = 68,136)



*Other includes Asian/Pacific Islander, Alaskan Native, and Native American MSM as well as those of two or more races.

1 CDC. Trends in HIV/AIDS diagnoses—33 states, 2001–2004. *MMWR* 2005;54:1149–1153.

2007 Prioritized Recommendations:
As Identified by the African American Advisory Committee

Epimeidiological Data

The 2001 monograph included recommendations for state and local health departments to address the challenges of HIV/AIDS in African American communities. In 2007, NASTAD's African American Advisory Committee reviewed those recommendations and prioritized those that they believe will yield the most robust response in mitigating the epidemic among African Americans. The prioritized recommendations that follow are a subset of the larger list of 2001 recommendations. See Appendix 1 for a list of complete recommendations by key issue area.

Utilize epidemiological data to inform ongoing dialogue and planning of HIV prevention and care services.

Data deemed important and compelling should be used to inform HIV/AIDS prevention and care planning in jurisdictions within HIV prevention community planning groups and Ryan White Program planning groups. Such an approach would build confidence that data is being used to make resource allocation decisions and that resources are following the epidemic.

Convene an African American HIV epidemiology work group.

The work group would establish an ongoing collaborative relationship with HIV/AIDS surveillance programs to interpret and present epidemiological data using language that is culturally specific, relevant, and written at an appropriate comprehension level, depending on the audience.

Fund and support efforts to increase the participation of African Americans in the field of epidemiology and behavioral science.

Identification of resources is necessary to support training programs, internships, and other career opportunities to encourage African American students and employees to pursue careers in epidemiology and related fields of public health.

A Successful Strategy: **Epidemiological Data**

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Objectives of Strategy

In the *HIV Continuum of Care Comprehensive Plan*, the Needs Assessment Committee and the Statewide Coordinated Statement of Need (SCSN) Committee of the Michigan HIV/AIDS Council (MHAC) were instrumental in developing a sound foundation upon which the 2004 *Comprehensive Plan* was based. The *Comprehensive Plan* presented a detailed outline of the path down which Michigan's Title II Continuum of Care program intended to travel through 2006. The plan followed three critical issues as the framework.

- Critical Issue A: Collaborate with other health care delivery services to maximize resources.
- Critical Issue B: Reduce and/or eliminate barriers to care.
- Critical Issue C: Develop standards and evaluate the impact of services on individuals.

From an epidemiological perspective, the State of Michigan sought to use the data collected in HIV Counseling, Testing, and Referral; Health Education Risk Reduction; and the HIV Event System to link with and compare to data collected through surveillance and the Uniform Reporting System (URS). Critical planning steps included:

1. The use of the Epidemiologic Profile of HIV/AIDS in Michigan, produced by the MDCH/Bureau of Epidemiology. The comprehensive profile draws from a number of data sources. The profile is an analysis where many different data sets are presented to provide robust representations of particular sub-populations. The profile provides detailed descriptions of the general population of Michigan as well as a

discussion on special populations such as foreign born, homeless, commercial sex workers, rural, and incarcerated. Additionally, a section highlighting health disparities has been added. Finally, discussions about individuals who were diagnosed with HIV and AIDS at the same time (concurrent diagnoses) were added.

2. Michigan Department of Community Health/ Division of Health, Wellness, and Disease Control (MDCH/DHWDC) compares HIV/AIDS Reporting System (HARS) data with URS data to identify gaps in care, including primary medical care.
3. MDCH/DHWDC analyze data collected from care and prevention programs to better understand the extent to which prevention services are also being utilized by individuals receiving care services.

Approach

During 2003, MDCH/DHWDC collaborated with the MHAC Needs Assessment Committee to develop and implement a comprehensive needs assessment plan for HIV/AIDS care services in the State of Michigan. The 2005 *Statewide Prevention Comprehensive Plan* cited efficient and timely access to medical, prevention, and support services as a key strategy to prevent HIV transmission for all risk populations. Additionally, the 2005 plan included a goal to collaborate with Bureau of Epidemiology colleagues to rapidly identify and curtail Sexually Transmitted Disease (STD) outbreaks and other unusual occurrences.

Three data collection strategies were employed in 2003 during the needs assessment process: (1) distribution of a People Living with HIV/AIDS (PLWH/A) survey, of which 1,006 were completed and returned; (2) nine PLWH/A open forums conducted throughout the state where a total 229 participants attended; and (3) 40 provider interviews which were conducted with case managers and client advocates.

The results of the needs assessment were used to help develop the state Request for Proposal (RFP) and Statewide Coordinated Statement of Need (SCSN) and will continue to be relied upon to help guide future

HIV/AIDS care service planning. Activities associated with successful coordination of the Comprehensive Plan included the following listing:

- Statewide Coordinated Statement of Need (SCSN)
- Needs Assessment
- RWCA Title II Application
- Comprehensive Plan
- Care RFP
- Continuum of Care Progress Reports and Ryan White CARE Act and data reports
- Financial Status Reports
- Compliance with HRSA's Issue: Administrative Costs

Challenges

The understanding and interpretation of epidemiological data at health departments can be difficult and challenging to comprehend. Secondly, when applying the data to decision-making and service delivery, all health departments must use the same methodology of applying the data across national, state, and local health departments. This can be a major task for health departments in interpreting the data at all levels. A third major barrier can be the use of multiple data collection systems. With the use of prevention, surveillance, care, and STD data collection systems, the barriers consist of providing funding for support of multiple systems and the integration of multiple datasets to produce and compare client-level data for unduplication and reporting.

Results

Through these efforts, MDCH produced a clearly-articulated *2006 Profile of HIV/AIDS in Michigan*, analyzed by sociodemographic markers such as race/ethnicity, age and sex, poverty, income, and education. The profile accounts for the vast total population of Michigan, the eighth largest population in the U.S. Results include a coordinated system of care based on surveillance data to Uniform Reporting System (Care Data), which is responsive to the number of African Americans brought into care or who received a care service in the state. Further, the state profile considers both the Detroit Eligible Metropolitan Area (EMA) and smaller county and rural areas.

Additional attributes in the 2006 plan noted "rural-ness" as a barrier to service in non-urban and non-suburban communities in the state.¹⁰ Rural-ness describes communities that have a limited HIV/AIDS service infrastructure, largely due to the fact that the number of persons in need of HIV-related services is low compared to urban and suburban communities. Rural-ness was cited along with other primary barriers to service care such as stigma, fragmented service delivery, restrictive climate in correctional facilities, and exhaustion, to name a few.

Additional results occurred when MDCH/DHWDC took steps toward strengthening its relationship with the Michigan Chapter of the National Association of Social Workers to explore and support issues related to HIV. Potential outcomes of the relationship may include the following: enhanced mental health services for PLWH/A; improved relationships between case managers and managed care, foster, and support agencies; dissemination of information about HIV/AIDS resources; and training for social workers on HIV issues and assistance with revising current HIV/AIDS standards of care.

Closing Thoughts

The following vision, first articulated in the *2001 Statewide Coordinated Statement of Need*, is also the vision which guides this document:

"Through compassion, commitment, trust, and self-advocacy, we aspire to develop and maintain a coordinated system of HIV/AIDS services that minimizes the further spread of HIV, provides financial protection from the costs of ill-health, promotes holistic health and well-being, affirms the human right to dignity and respect, generates active membership within our communities, and strengthens cultural awareness and support for diversity."

Resources

A full account of the needs assessment results can be reviewed in two documents entitled "*2003 Title II HIV/AIDS Care Needs Assessment*" and "*2003 Detroit Eligible Metropolitan Area HIV/AIDS Care Needs Assessment*."

Note:

See Appendix 3 for other successful strategies.

Key Issues: Capacity Building

“Over the past five years, the most profound capacity building efforts in the health care fields for the African American community have been based on the National Standards for Culturally & Linguistically Appropriate Services in Health Care (CLAS) issued by the Office of Minority Health. These standards remain salient guideposts consistent with respect for the expertise, wisdom and knowledge inherent in our communities.”

Barry D. Walston

The AIDS Institute of the New York State, Department of Health

The 1999 passage of the Minority AIDS Initiative (MAI) in Congress increased funding for capacity building targeting African American communities at local, state, and national levels. As part of this process, health departments enhanced their coordination of programs for African Americans and in many cases facilitated capacity building assistance for organizations based in African American communities. The 2001 monograph addressed capacity building at two distinct levels—within health departments themselves and with community based organizations (CBOs) supported by health departments. Six years later, work at the health department and CBO levels remain critical to the emergence of innovative capacity building that serves members of the target population who often lead the most successful CBOs. They are more likely to understand the needs and perspectives of communities and deliver information and services in the context of building relationships, trust, and credibility with members of communities.

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There is compelling evidence that African American CBOs help meet the needs of their communities; however, they often require technical assistance and training from health departments and other entities to reach the next levels of capacity necessary to fulfill the programming needs of their constituencies. As the nuances of the epidemic become more challenging, implementation of effective, adequate, and sustainable prevention, treatment, and care programs, particularly those located in disenfranchised communities, require a more sophisticated capacity building plan and keen technical skills. Lessons learned from national initiatives identify capacity building as a long-term process, thereby increasing the opportunities for CBOs and non-governmental organizations (NGOs) to better implement and manage their programs. Finally, in an environment of decreased funding, African American organizations with cultures of empowerment and learning through infrastructure development and capacity building are best positioned to realize maximum returns.

Health departments are expected to provide the leadership necessary to plan for and address the key competencies in specific areas of HIV/AIDS such as counseling, testing, and referral services (CTR); partner counseling and referral services (PCRS); case management; primary medical care; prevention for positives; and support services for African American providers. Capacity building action plans should be developed for the specific and individualized capacity building needs of organizations, determined through formal needs assessments, coordinated on-site technical assistance, and a training taxonomy based on organizational infrastructure and programmatic elements. Innovative capacity building initiatives should include technological advances such as video and web-based training curricula as well as secured funding

streams for capacity building and training, in order to increase competencies of community stakeholders.

Health departments are charged with oversight of a magnitude of service mandates and may often find themselves prime candidates for capacity building services, particularly in areas related to cultural competency, sensitivity, diversity, and service needs paramount to African American communities. In this regard, health department staff should also participate in capacity building opportunities available via federally-

funded capacity building assistance and support initiatives. Knowledge of peer consultation programs

and technical assistance expert databases are key resources for health departments and CBOs to access. Strategic planning to address the necessary training needs of AIDS directors and various health department staff may also provide proactive opportunities for the development of policies and practices that are culturally appropriate and relevant to African American communities.

2007 Prioritized Recommendations:

As Identified by the African American Advisory Committee

Capacity Building

The 2001 monograph included recommendations for state and local health departments to address the challenges of HIV/AIDS in African American communities. In 2007, NASTAD's African American Advisory Committee reviewed those recommendations and prioritized those that they believe will yield the most robust response in mitigating the epidemic among African Americans. The prioritized recommendations that follow are a subset of the larger list of 2001 recommendations. See Appendix 1 for a list of complete recommendations by key issue area.

Create a Minority AIDS Coordinator position in health departments serving jurisdictions with a large African American population.

During the drafting of the 2001 monograph, the role of a Minority AIDS Coordinator was deemed a priority in helping to make all information and processes culturally relevant within the health department and to ensure African American participation at all levels of HIV/AIDS policy development and program implementation. Several jurisdictions created an appropriate position to address this major concern. See Appendix 5 for sample job descriptions of a Minority AIDS Coordinator. Given the success in these jurisdictions, the African American Advisory Committee still deems this recommendation paramount for all jurisdictions in addressing disproportionate rates of HIV infection in African American communities.

Take a top-down approach.

Capacity building efforts are taken most seriously and tend to be most effective when they originate at the top. AIDS directors in health departments can provide leadership and support for capacity building efforts from the top by communicating that the efforts are a high organizational priority, by getting buy-in from other leaders and managers in the organization, and by allocating adequate funding for capacity building initiatives.

Conduct a cultural competency assessment of the health department (and/or the AIDS office within the health department).

The purpose of conducting a cultural "audit" is to assess the degree of cultural competency or proficiency in health department HIV/AIDS offices. Cultural competency enhances the department's effectiveness in addressing the HIV prevention and care needs of African American populations.

A Successful Strategy: **Capacity Building**

Project Title: The New York State Prevention Planning Group Racial/Ethnic Committee Programming

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Objectives of Strategy

The New York State (NYS) HIV Prevention Planning Group (PPG) developed a resolution for an African American/Black Initiative, which was adopted January 26, 2000. Specific language included "Resolved that the New York State HIV Prevention Planning Group will address the crisis in African American/Black communities as a priority focus in all HIV prevention planning work both as a full group and within each population committee." The resolution acknowledged the state of emergency in the NYS African American/Black community and the PPG's commitment to address the emergency.

The resulting African American/Black Initiative model was launched and became so effective that it was replicated and expanded to all communities of color via a *Reaffirmation of Our Commitment to Meeting HIV Prevention Needs of Communities of Color* on April 9, 2003. The AIDS Institute's proactive involvement was evidenced immediately following the release of NASTAD's African American monograph in 2001. A 2002 Communities of Color work group, an advisory group of the AIDS Institute comprised of staff of color, was recommended. The work group sponsored community forums to respond to the monograph's recommendations as well as recent HIV/AIDS epidemiological data in NYS.

The African American/Black Initiative

The NYS PPG established population-based committees to guide activities. Information and data was used from a diverse array of evidence-based approaches and sources. The PPG recognized from the onset the significance of additional sociocultural aspects that informed and enhanced programming. These factors included external factors, historical underpinnings, cultural norms, and barriers to access. The PPG provided recommendations to the AIDS Institute on ways and means to implement priority HIV programs and interventions for African American/Blacks and, later, all specific populations and subpopulations.

The initiative sponsored major events and activities such as working forums, breakfast sessions, and expert population-based sessions. Sessions often sought to familiarize PPG members and community stakeholders and leaders with the work of the PPG working group over the life of the initiative and the closer impact of HIV/AIDS on African American/Black sub populations. Specific program activities included:

- Voices from the Communities of Color: A Tapestry of HIV Prevention (October 2005)
- The African American HIV/AIDS Working Forum to Address Capacity Building Strategies (October 2005).
- A Day of Focus on African American/Black Heterosexual Men (November 2005)

Approach

The African-American/Black Initiative was organized through the membership of the NYS PPG Racial/Ethnic Committee with the support of NYS Department of Health (DOH) liaison. The efforts of the above initiatives, resolutions, and forums were conducted through a collaborative effort with NYS-DOH-identified staff and its community partners of the NYS PPG. Additionally, good leadership was supported within the PPG making the approach/buy-in transparent to the government and the community.

Challenges

- In crafting and finalizing the Resolution, relationship building with a broad and diverse PPG membership proved challenging. Also, ensuring the NYS DOH remained neutral, yet supportive, was also a challenge.
- During the American African forum sponsored by the NYS DOH, balancing voices from DOH and community stakeholders was necessary, yet difficult to facilitate.

Results

The results of the above activities were evidenced in many ways, including strengthened relationships between community partners and government; empowerment of the NYS PPG members; empowering the voices of PPG members; and the inclusion of information from the forum and focus groups into the NYS DOH Request for Applications (RFA) processes. The Initiative also serves as a model for other NYS DOH internal activities.

Closing Thoughts

- The AIDS Institute's Communities of Color Internal work group developed a (NYS) statewide capacity building forum for community based organizations of color and they developed and implemented an evaluation of the forum;

- Community focus groups were held throughout the entire state to foster community buy-in and support;
- Ryan White CARE Network coordinators were invited to participate and to nominate two consumers from their region to attend;
- Major and minor themes were identified from forum participants;
- Feedback from forum focus groups and PPG members shaped the developments of all new RFA; and,
- As a standard, PPG members are included as reviewers of RFAs.

Resources

- The African American/Black Initiative Document (January 2003)
- Communities of Color Summary/Lessons Learned Document (September 2003)
- *Voices from Communities of Color: A Tapestry of HIV Prevention* (October 2005)
- *Women in Peril HIV/AIDS: The Rising Toll on Women of Color* (December 2005)
- The African American HIV/AIDS Working Forum Summary Report

Note: See Appendix 3 for other successful strategies.

Key Issues: **Coalition and Partnership Building**

“The faith community in Maryland has a desire to do something. Some are bold, while others must train their parishioners about the devastating impact of HIV/AIDS and why they have to address the epidemic from a spiritual perspective.”

Barbara Simpson Epps

Formerly with the State AIDS Administration,
Maryland Department of Health and Mental Hygiene

For generations, partnerships, with and within communities, have been an integral component to creating change and improving health status. Over the next few years, synergy between health departments and organizations poised to serve and represent African American communities must be enhanced. Community engagement models must be rigorously employed to fortify the foundation of these efforts. Health departments must assist with strengthening partnerships with African American organizations. Strategies employed by health departments must address both components with a greater effort to join forces with traditional and nontraditional CBOs and leaders working with African American communities. Mobilization and community-wide interventions can be employed via regional, statewide, and local conferences, educational and awareness events, and task forces.

A multi-sectored approach is necessary to abate the sentiment that the nation’s powerbrokers have

abandoned the HIV/AIDS epidemic in African American communities. With its support and investment in community engagement and partnership building, health departments serve as a major force in this effort. Community members also have a significant role to play. Additional major stakeholders in these collaborative efforts include health workers, healthcare professionals, physicians, outreach workers, psychologists, social workers, community development programs, departments of corrections, academic institutions and researchers, sports leagues, planning and health consortia, faith institutions and clergy, journalists, community leaders, private and government funders, foundations, and policy makers. Moving forward, communities must rally and unite, beyond annual awareness day activities, to garner commitment to self-responsibility and self-determination to promote a unified mission that is sustainable. To reiterate, health departments have been, and must continue to be, a key stakeholder in the coalition and partnership equation.

2007 Prioritized Recommendations:
As Identified by the African American Advisory Committee

Coalition and Partnership Building

The 2001 monograph included recommendations for state and local health departments to address the challenges of HIV/AIDS in African American communities. In 2007, NASTAD's African American Advisory Committee reviewed those recommendations and prioritized those that they believe will yield the most robust response in mitigating the epidemic among African Americans. The prioritized recommendations that follow are a subset of the larger list of 2001 recommendations. See Appendix 1 for a list of complete recommendations by key issue area.

Be aware of the traditional mistakes that health departments make when helping CBOs build collaborations.

There are a number of common mistakes that health departments make when helping CBOs build partnerships. One is repeatedly looking to the same organizations to partner simply because their grant-prescribed activities are similar. Another is thinking that opinion leaders in African American communities are those individuals with the highest public profile or those involved in traditional health department planning activities.

Build coalitions and partnerships with stakeholders who represent a broad range of African American constituencies.

Health departments should think creatively when building partnerships. There are a broad range of groups with which to partner and collaborate including indigenous African American community leaders and stakeholders and established coalitions addressing related issues such as teen pregnancy, violence, substance abuse, housing, employment, and civil rights. Health departments should work with the faith community, educators, writers, artists, and media groups. Other constituent groups include state elected officials, groups that serve constituencies at highest risk including gay, lesbian, bisexual, and transgender organizations, and CBOs serving women and youth.

Foster coordination and collaboration within the health department itself.

There are many individual programs within health departments whose effectiveness in African American communities could be enhanced by coordinating efforts, sharing resources, and collaborating. These include maternal and child health, STD prevention and treatment, substance abuse prevention and treatment, juvenile justice, violence prevention, community health, and Emergency Preparedness.

A Successful Strategy: **Coalition and Partnership Building**

Project Title: The Faith-Based Initiative

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Objectives of Strategy

The Faith-Based Initiative is coordinated by the AIDS Administration's Office of Community Relations & Initiatives (OCRI), which operates under the Office of the Director. OCRI is dedicated to assisting state and local government agencies and private and public groups in efforts geared towards the reduction of morbidity and mortality associated with the transmission of HIV/AIDS. In keeping with its mission, OCRI has implemented a logic model, which facilitates partnerships with leaders of Maryland's faith community to confront the epidemic of HIV and AIDS. Presently, OCRI is implementing year two of the strategic three-year plan.

The Faith-Based Initiative

The Maryland State AIDS Administration, in compliance with the President's Executive Order, has partnered with faith leaders of Maryland to strengthen their capacity to better meet the HIV/AIDS prevention education and service needs of the community. The AIDS Administration has:

1. Formed a statewide Faith Advisory Board with authentic representatives across faith communities.
2. Operationalized established goals outlined in the strategic plan.
3. Created, located and/or revised, appropriate curriculum and materials.
4. Included the promotion of national HIV/AIDS observance days.
5. Utilized evaluation tools to measure the effectiveness of targeted workshops and conference.

6. Identified relevant funding source opportunities for faith communities.

Approach

The Faith Based Initiative is a partnership between the Administration and the faith community in the state of Maryland. The mission of the Initiative is to collaborate with faith leaders to develop responsible and effective prevention programs to increase the awareness of the HIV/AIDS epidemic throughout the state. The Initiative is further guided by a formal strategic plan comprised of realistic and attainable goals. Such focus has resulted in a training and events calendar for 2007 that includes a series of ten trainings to be held three times annually for a total of 30 trainings each year. The strategic plan also includes three faith-based conferences designed for regional impact and inclusive of all faith communities. The Initiative was presented and well received at the 2nd National Methamphetamine, HIV and Hepatitis Conference, held in Salt Lake City, Utah in early February 2007.

Challenges

The single largest challenge is the acquisition of funding for sustainability beyond the two-year program.

Results

- 30-40 faith leaders are actively involved in the Initiative with regional representation across the state and across faith organizations (Christian, Muslim, and Jewish);
- By mid-January 2007, faith partnerships were established for more than 60 percent of all workshops scheduled and 50 percent of those attending the first quarterly Faith Advisory Board meeting were new to the board;
- To date, 90 percent of the participants are African American;
- The 2007 Training and Events Calendar Planned workshop schema includes:
 - Basic HIV/AIDS 101

- Conducting Street Outreach
- HIV & Youth
- HIV & Women
- HIV & Men
- HIV Issues for Parents
- HIV & Mature Audiences
- Becoming a 501(c)3
- Funding Resources
- HIV Care & Counseling

Lessons Learned

- College internships and volunteer agencies can play a vital role with program evaluation and implementation;
- Faith community culture acknowledges the importance of individual relationship and referral;

- Many faith organizations operate at a grass-roots level without connectivity to larger national boards or associations;
- National board and/or association approval facilitates geographic sanctioning and participation;
- A large portion of the requested technical assistance centers around community marketing and promotional materials;
- In-kind partnerships are a well received strategy for collaborations; and,
- National conference promotion and recognition will facilitate adaptation to other faith communities.

Resources

- The Faith Based Initiative Work Plan 2006-2009
- The Faith Based Training & Events Calendar

Note:

See Appendix 3 for a list of other successful strategies.

Key Issues: Program Implementation

“When developing programming in rural or frontier states, the participation of a variety of partners is essential. What worked in Nebraska was to convene non-health focused agencies as well as public health partners to address a huge problem in the African American community. Our results were rapid, effective, and to this point, sustained because of the efforts of the community responding to a public health crisis.”

Steve Jackson

Nebraska Department of Health

Program implementation overlaps with other areas cited in this monograph, creating opportunities for strong impact and major outcomes. Scaled-up programs must be supported by health department investment and innovative program designs, development, implementation, and evaluation based on best practices and proven interventions that work for African American communities. The broad recommendations in the 2001 monograph—cultural sensitivity, appropriateness, collaborations, culturally diverse staff, and strategies to address known and unknown barriers—must continue to be addressed, keeping local geographical constraints and resources in mind. Prioritization of interventions and target populations, including African American heterosexual women, incarcerated persons, men who have sex with men, youth, and injection drug users must also be taken into account.

Health departments must develop and adhere to program implementation guidelines and protocols set forth through the Healthy People 2010 goals established by the federal government, along with a specific emphasis on prevention and treatment of the co-factors of HIV/AIDS. Co-factors include substance use, mental health, reproductive health, poverty, homelessness, and other health disparities. Health departments must expand their efforts beyond funding to include human resources by way of building partnerships and coalitions.

A systems perspective will benefit health departments and a host of community-based partners, as well as African American at-risk populations who are the major source of discussion and planning. Clear-cut and precise programmatic goals and objectives must be developed and communicated nationally, regionally, and locally.

In this regard, NASTAD's African American Advisory Committee is committed to working collaboratively and synergistically to develop the future architecture of this mission as it relates to health departments and their HIV/AIDS programmatic engagement with African American communities.

New Considerations

Released in 2003, CDC's new initiative, *Advancing HIV Prevention: New Strategies for a Changing Epidemic* (AHP), presented four key strategies for moving HIV prevention forward in the U.S.:

- Make HIV testing a routine part of medical care.
- Implement new models for diagnosing HIV infections outside medical settings.
- Prevent new infections by working with persons diagnosed with HIV and their partners.
- Further decrease perinatal HIV transmission.

The strategies place an increased emphasis on identifying new cases of HIV, particularly among individuals who are living with the virus but are unaware of their status. To support this strategy, CDC has intensified its focus on HIV testing and partner counseling and referral services by introducing methodologies to assist in the identification of new cases, including several pilot projects and the September 2006 release of the *Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings*. To support CDC's efforts, AIDS directors are encouraged to consider these new methodologies in light of the specific needs and realities within their given jurisdiction. Where appropriate, these tools can be used to help advance the goal of identifying new HIV infections in support of local HIV prevention and care and treatment priorities.

Finally, AIDS directors, their staff and the communities they serve are strongly encouraged to leverage scarce HIV/AIDS, STD and viral hepatitis resources and look for opportunities to integrate programs and services wherever possible.

Concurrent with the release of AHP, CDC intensified its efforts to replicate and diffuse an ever-growing set of science-based effective behavioral interventions. The Diffusion of Effective Behavioral Interventions (DEBI) project intends to bring these community-level and group-level interventions to HIV prevention programs

in state and local health departments and community-based organizations. AIDS directors and their staff are encouraged to consider these interventions as tools to use in the context of their own HIV programs, as appropriate. At this point in time, CDC only encourages, but does not mandate, the use of these interventions by state and local health departments.

Finally, AIDS directors, their staff and the communities they serve are strongly encouraged to leverage scarce HIV/AIDS, STD and viral hepatitis resources and look for opportunities to integrate programs and services wherever possible. Moreover, AIDS directors are encouraged to partner with programs addressing other key health concerns affecting African American communities, including substance abuse, mental health and violence prevention.

2007 Prioritized Recommendations:

As Identified by the African American Advisory Committee

Program Implementation

The 2001 monograph included recommendations for state and local health departments to address the challenges of HIV/AIDS in African American communities. In 2007, NASTAD's African American Advisory Committee reviewed those recommendations and prioritized those that they believe will yield the most robust response in mitigating the epidemic among African Americans. The prioritized recommendations that follow are a subset of the larger list of 2001 recommendations. See Appendix 1 for a list of complete recommendations by key issue area.

Support the implementation of reputable programs.

Health departments need to implement prevention and care programs that are high in quality and efficacy. This includes implementing interventions that have achieved positive outcomes despite lack of formal process or outcome evaluation.

Provide seed money to encourage and fund community-based African American HIV/AIDS initiatives.

Health departments should pay special attention to those programs addressing the diverse needs of the highest-risk populations within the African American communities, with or without state or local funding.

Provide funding and capacity building assistance to CBOs for the evaluation of prevention and care programs.

Quality management within prevention and care programs should be regularly evaluated to identify areas in need of improvement as stipulated in federal, state, and local guidelines. Evaluation data should also be used for designing new programs that are built on strategies shown to be effective.

A Successful Strategy: Program Implementation

Project Title: Milwaukee Alliance for Sexual Health (MASH)

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Description

Milwaukee Alliance for Sexual Health (MASH) was launched in June 2006 through a six-month planning grant to conduct a needs assessment and programmatic activities. The project seeks to reduce the rates of sexually transmitted diseases (STD) and unintended pregnancies (including subsequent births) among African American youth ages 15-19 in Milwaukee. The project will impact the community's health through the development of public and community health leadership and policy by promoting high levels of awareness, readiness, and commitment from the community to take action to address disparities in STDs and unintended pregnancies.

Objectives of Strategy

- Improving understanding of the morbidity and impact of STDs and unintended pregnancies (including subsequent pregnancies) among minority communities in Milwaukee, particularly in the zip codes with the highest STD and teen pregnancy rates;
- Raising community awareness of the alarming rates of STD infection and unintended pregnancies in Milwaukee and the disproportionate impact of these preventable health conditions on minority communities;
- Identifying opportunities for creative resource sharing, service coordination, and program development among existing STD, HIV/AIDS, family planning, and other public health services to improve access and utilization of existing services,

particularly the Wisconsin Family Planning Medicaid Waiver Program; and

- Mobilizing community leadership into action to secure new resources to implement proven public health STD and pregnancy prevention interventions and services.

Approach

The proposed project addresses the *Healthier Wisconsin 2010* health risks of high-risk sexual behavior, communicable diseases, and access to primary and preventive health services. The project focuses on the special populations of children and adolescents and racial and ethnic populations in urban settings.

The planning initiative was comprised of a three-fold strategy:

1. Facilitated focus groups with youth within corrections facilities, schools, alternative programs, and faith based programs.
2. Youth were identified to conduct interviews with their peers.
3. Partnerships with research fellows were established to generate white papers on sexual health.

Using the Mobilizing for Action through Planning and Partnerships (MAPP) process as a framework for the project's community planning and mobilization process, the project implemented three core strategies:

Strategy 1: Conduct enhanced analysis of Wisconsin surveillance and other epidemiologic data to improve understanding and promote awareness of STDs and unintended pregnancies.

Strategy 2: Implement a resources and best practices inventory to assist in identifying strengths and gaps in the current service system, allowing for prioritization of areas for systems improvement.

Strategy 3: Facilitate a short-term, outcome-focused community planning and mobilization process that convenes diverse community and provider stakeholders.

Results

- The timing of this initiative paralleled major new efforts by the Department of Health and Family Services, Division of Public Health, and the City of Milwaukee Health Department to address health disparities among racial and ethnic minorities in Milwaukee;
- Established community groups with active involvement by consumers were sought for engagement, including the Wisconsin HIV Prevention Community Planning Council and the Black Health Coalition's African American HIV/STD Task Force;
- The program planning grant will result in a comprehensive plan to implement findings;
- Community voices and input were increased via the program's activities;
- The project worked closely with the Syphilis Elimination Project's Community Partnership Team (CPT) to raise awareness and interface and mobilize the community; and
- Issue papers resulting in preliminary recommendations, community meetings and buy-in, and a follow-up strategic plan are slated for 2007.

Way Forward

- Include in-kind resources. Funding available through the Division of Public Health included significant in-kind staff and other resources to support the implementation of Strategies one and two during the first six months of the project;
- Seek and expand potential funding sources. The project planned to submit a Rapid Assessment, Response, and Evaluation (RARE) application to the federal Office of Minority Health to support a proposed enhanced community assessment and epidemiologic activities;
- Project coordinators designed a plan for dissemination, replication of results, and next steps;
- Commitment and capacity to achieve Community-Academic Partnership Model was a key project benefit;
- Communication to the public was used to convey how the proposed project will increase their quality of health.

Note:

See Appendix 3 for a list of other successful strategies.

Key Issues: Behavioral Research

"Over the past five years we identified how research impacts our work—now we need to do the work and take the lead in research by training and nurturing our own researchers."

Gina Lathan Whitener

Illinois Department of Public Health, HIV/AIDS Section

Since the release of the 2001 monograph, the nation's public health community has experienced heightened recognition of the vital role of behavioral research in addressing the HIV/AIDS crisis in African American communities. In many instances, health department officials led the effort by including grant and contract requirements that program interventions be grounded in science. Throughout these efforts, health departments also internally sought to better understand the myriad needs and concerns of African Americans about HIV/AIDS and health highlighted through research findings. This includes generating deeper knowledge of the specific combinations of co-factors that continue to put African Americans at risk (e.g., deep mistrust of the public health system, low health-care-seeking behaviors, lack of well-funded and culturally-specific interventions, and stigmatization within communities). A more thorough understanding of how to effectively intervene with those at highest risk is also paramount in the future response to the domestic HIV/AIDS crisis. Scaled-up approaches, using epidemiological and surveillance data that demonstrate the need to target African American communities, especially heterosexual women and men who have sex with men (MSM), should be implemented.

The 2001 monograph stipulated that there must be a shift in the public health approach to HIV/AIDS in African American communities. Communities have since been infused with prevention interventions designed for African Americans at risk for HIV/AIDS, some of which are supported by the Centers for Disease Control and Prevention (CDC) through national training and capacity building efforts. The increasing awareness

and engagement of behavioral science research at the ground level has been championed by African American researchers as well as researchers interested in African American issues (see Appendix 4). Broader research on various populations within the African American Diaspora will allow us to better understand HIV trends and factors as they pertain to the various subgroups in the U.S. Such research will also shed light on the links between the behaviors of African Americans and the rising HIV infection rates for African Americans nationwide. Possible directions for quantitative and qualitative studies include the role of media; HIV, viral hepatitis, and STD co-infection; identity construction of African American men and women; and the role of spirituality and the Black church.³

Broader research on various populations within the African American Diaspora will allow us to better understand HIV trends and factors as they pertain to the various subgroups in the U.S.

As in the past, future behavioral research must be conducted with consideration of historical underpinnings and an awareness of, and respect for, the vast African American experience. We have learned many lessons, particularly that behavioral interventions that work for one sub-population of African Americans may not work for another. Therefore, additional interventions and work in knowledge and information transfer from researcher to practitioner are needed to

address the growing prevention and care needs of this diverse population.

Future priorities for behavioral research must include a willingness of AIDS directors to effectively advocate within their health departments for policies and practices that are culturally appropriate and relevant to

African American communities. These practices should be augmented with an expanded focus of program evaluation to include outcome and impact measures in order to advance knowledge of what works in African American communities. Partnerships and linkages between health departments, CBOs, and behavioral scientists are key strategies in realizing these efforts.

2007 Prioritized Recommendations:
As Identified by the African American Advisory Committee

Behavioral Research

The 2001 monograph included recommendations for state and local health departments to address the challenges of HIV/AIDS in African American communities. In 2007, NASTAD's African American Advisory Committee reviewed those recommendations and prioritized those that they believe will yield the most robust response in mitigating the epidemic among African Americans. The prioritized recommendations that follow are a subset of the larger list of 2001 recommendations. See Appendix 1 for a list of complete recommendations by key issue area.

Promote linkages between CBOs and behavioral scientists.

Behavioral scientists represent the scientific establishment to African American communities via public health departments. The CBOs represent African American communities to the behavioral scientists. Based on historical underpinnings, the relationship between behavioral scientists and CBOs are wrought with mistrust. To address effectively the impact of HIV/AIDS on African American communities, this relationship must be improved through promotion of linkages between these two groups.

Include representatives from communities at highest risk in outcome evaluation design and implementation.

Organizations serving African American communities and community leaders themselves must be an integral part of evaluation design and implementation processes.

Identify opportunities for outcome evaluation.

Outcome evaluation is necessary so that program planners and developers can determine program success. The results of these evaluations should be shared with community stakeholders in order for everyone to benefit.

A Successful Strategy: Behavioral Research

Project Title: College and University Partnership Research Project Initiative

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Objectives of Strategy

With the understanding that African Americans are more likely to understand the needs and perspectives of their own communities, the College and University Partnership Research Project intended to address and combat disparities in HIV/AIDS infection rates among the African American community in Illinois. The primary goal was to create a research and policy infrastructure in the African American community to help facilitate the delivery of effective HIV/AIDS prevention, care, and treatment services to African Americans through the integration of research-based projects in predominately African American organizations, associations, and faith-based entities. The strategy design was college and university-focused with emphasis on training graduate and undergraduate students to understand the importance of research and its link to abating the further spread of HIV in African American communities. The research projects were broad and varied in scope—a social marketing campaign, a female condom demonstration, an African American male sexual behavior survey in the African American church, and a data management system to collect and analyze data.

The College and University Partnership Research Project initiative was developed and implemented by the Illinois Department of Public Health Office of the Director, Center for Minority Health Services, and the Office of Health Protection, HIV/AIDS Section. It began as a subcommittee of the African American HIV Epidemiology Committee, which was developed to provide a comprehensive and coordinated statewide response to the HIV/AIDS epidemic in African American communities throughout Illinois. Through the dedicated efforts of its sub-committees, high-quality, culturally-appropriate, and innovative HIV-related research, program initiatives,

and projects were implemented and made accessible to African Americans statewide.

The African American HIV Epidemiology Committee is comprised of three subcommittees, Social Marketing, Unity For Action, and College and University and Partnership. Each of the subcommittees developed objectives. In addition, the College and University Partnership subcommittee was charged with accomplishing the following objectives:

- Support the development of appropriate research regarding African American communities;
- Establish initiatives to hire, develop, promote, and retain African Americans in the field of public health research; and
- Identify, engage, and train indigenous members of African American leadership to become involve in the HIV/AIDS decision-making processes.

Approach

Partnering with colleges and universities throughout the state, research-based projects within predominately African American organizations, associations, and faith-based entities were implemented with the understanding that African Americans are more likely to understand the needs and perspectives of their own communities. In order to achieve this, the College and University Partnership subcommittee collaborated with colleges and universities throughout the state of Illinois. The subcommittee assisted in the selection of African American undergraduate and graduate students to serve as interns within partnering African American organizations to implement sustainable HIV/AIDS research-based prevention, care, and treatment projects.

This successful strategy employed a proactive plan to implement key recommendations in the 2001 NASTAD monograph. Initially, key stakeholders were convened to walk through the document over a series of meetings to ascertain the best methods for implementation. Thousands of copies of the monograph were widely distributed throughout the community and social marketing strategies, with an emphasis on establishing partnerships between African American researchers and the state health department, were employed.

Researchers identified performance measures so that the initiative could be benchmarked for success.

Final reports were generated on the diverse research projects representing the areas of need for service and research in the African American community with recommendations made in the areas of methodology, programs, and policy.

Challenges

- When students are used for projects, ensure that direct supervision is factored into the program design and work plan..
- Some research projects faced time constraints due to the identification of additional protocols..
- Data systems needed to be HIPAA compliant and compatible with contract requirements.
- There was a lack of staff to commit to the project.

Results

The project yielded significant results including an increased base of knowledge about the needs and self-identification of African American gay men; buy-in and support from the Illinois Department of Public Health allowed for the acquisition of additional funding to further the initiatives generated via the monograph; and a final report was produced by the project evaluator who also provided technical assistance to community based organizations. Other major results included the use of formative evaluation through surveys, research design, and methodology; community based organizations throughout Chicago were contacted to ensure representation of urban perspectives; projects examined science-based interventions with qualitative methods including focus groups and community forums; and key findings were recorded from each research project.

Lessons Learned

- A cogent program plan must include tools, data collection techniques, research models, rationale, and contribution to the field.
- College and university students and all staff must be formally trained to engage in research projects.
- Assign a mentor to each student along with a university liaison who is responsible for completion of the projects.

- Include a basic skills of research component to the scopes of contracts to ensure all students learn the basics of research design.
- Work with African American community based organizations to build their capacity in research and evaluation within their organizations.

Way Forward

- Additional research should be developed that addresses a more representative sampling.
- Additional resources should be given to undergraduate students when they are first exposed to culturally-sensitive research.
- Independent study credit awards should be given to graduate students as basic research methodology is either learned or enhanced through these projects.
- All projects should be required to understand the relationship between research and policy. This offers a practical framework for research and gives students an understanding of the value this work yields to the Illinois Department of Public Health.
- Research projects should seek additional funding opportunities to include more primary research.
- Research projects should be continued where possible, and funding stipends should be increased for graduate students.
- Graduate level work should be presented by the students at a year-end conference with specific policy recommendations from each project. State legislators and other policymakers should be invited.
- The African American HIV Epidemiology Committee should convene quarterly during the course of the projects to discuss and document accomplishments and fiscal and/or administrative barriers to success.
- The overall College and University Partnership subcommittee should convene quarterly to discuss, document, and present the research gains to appropriate policy makers.
- Each student should create policy recommendations to be compiled and distributed to appropriate state health department staff, policy makers, legislators, African American HIV Epidemiology Committee members, and academia.

Note:

See Appendix 3 for a list of other successful strategies.

Appendix 1

2001 Monograph Recommendations

**Note: Recommendations marked by an asterisk are ones that were selected by the African American Advisory Committee to be top priorities for 2007.*

Epidemiological Perspectives

***Convene an African American HIV epidemiology work group**

This work group would establish an ongoing collaborative relationship with an epidemiologist(s) to interpret and present epidemiological data in layman's terms and in language that is culturally specific, relevant and written at an appropriate reading level. Working relationships can be established with graduate schools of public health to ensure epidemiologists are trained to present data that is culturally relevant and can be understood by the public. Opportunities to develop partnerships and joint programs with historically black colleges and universities can also be explored.

***Utilize epidemiological data to inform ongoing dialogue and planning of HIV prevention and care services**

Building upon existing planning bodies, such as the prevention community planning groups and Ryan White CARE Act Title I planning councils and Title II consortia, data deemed important and compelling should be used to inform HIV/AIDS prevention and care planning in the jurisdiction. Such an approach would build confidence that data is being used to make resource allocation decisions, and that resources are tracking the epidemic.

***Fund and support efforts to increase the participation of African Americans in the field of epidemiology and behavioral science**

Jurisdictions may be able to identify resources to support training programs, internships and other career opportunities to encourage African American students and employees to pursue careers in epidemiology and related fields of public health.

Capacity Building (within health departments)

***Take a top down approach**

Capacity building efforts are taken most seriously and tend to be most effective when they originate at the top. AIDS directors in health departments can provide leadership and support for capacity building efforts by communicating that the efforts are a high organizational priority, by getting buy-in from other leaders and managers in the organization, and by allocating adequate funding for capacity building initiatives.

Consider multiple sources for obtaining capacity building in health departments

There are many sources from which health departments can obtain capacity building assistance and engage in collaborative training and research activities. These include national organizations, peer technical assistance coordinated by NASTAD, peer departments within the same health department, local colleges and universities, independent TA providers, and even the CBOs themselves.

Conduct an assessment of cultural competency of the health department (and/or the AIDS office within the health department)

The purpose of conducting a cultural "audit" is to assess the degree of cultural competency or proficiency in health department AIDS offices. Cultural competency will enhance the department's effectiveness in addressing the HIV prevention and care needs of African American populations. Cultural audits generally include gathering data through interviews, focus groups or surveys to diagnose areas of strength and are opportunity specific to workplace inclusion, diversity and cultural competency. Cultural audits can provide the foundation upon which specific capacity building

actions (e.g., staff development, management development, organizational development) can be designed and taken.

Offer educational workshops to health department managers and staff on the historical dynamics between racism, African Americans, HIV/AIDS and the public health system

Effective training programs will be both didactic and experiential. They will present the facts and facilitate meaningful dialogue in a non-threatening environment.

Offer management development training with a focus on cultural competency

Areas to address in management development training include skills and best practices for recruiting, hiring, developing, promoting and retaining African American and other minority staff at all levels of the organization. Managers may also want to offer training for less experienced African American health department staff to help with feelings of intimidation, confusion or manipulation.

***Create a Minority AIDS Coordinator position in health departments serving jurisdictions with large African American populations**

The role of a Minority AIDS Coordinator would be to help make all information and processes culturally relevant within the health department, and ensure African American participation at all levels of HIV/AIDS policy development and program implementation (see Appendix 4 for suggested position requirements). In jurisdictions where African Americans are heavily impacted by HIV/AIDS, every effort should be made to identify an African American candidate for this position. To avoid marginalization of the position and the individual holding it, it is essential that the Minority AIDS Coordinator be fully integrated into the management structure of the health department, so that the position is not seen as "just another special initiative."

Coalition and Partnership Building

***Be aware of the traditional mistakes that health departments make when helping CBOs build collaborations**

There are a number of common mistakes that health departments make when helping CBOs build partnerships. One is repeatedly looking to the same organizations to partner simply because their grant prescribed activities are similar. Another is thinking that opinion leaders in African American communities are those individuals with the highest public profile, or those involved in traditional health department planning activities. Successful partnerships can, and often do, originate out of unique or unexpected alliances.

Health departments should think creatively when building partnerships. There are a broad range of groups to call upon locally including indigenous African American community leaders, opinion leaders, and stakeholders, as well as established coalitions addressing related issues such as teen pregnancy, violence, substance abuse, housing, employment, and civil rights. Health departments should work with the faith community, with educators, with writers, artists and media groups. Steps should be taken to educate and involve state elected officials, especially African American representatives in state legislatures, about the HIV epidemic in African American communities. It is imperative to also include those groups that work with African American organizations serving constituencies at highest risk including gay, lesbian, bisexual, and transgendered organizations along with women- and youth-serving CBOs.

Health departments should also consider partnering with public health departments in other jurisdictions that serve African Americans and build relationships with state and local counterparts of national fraternities, national minority AIDS organizations, national minority trade associations, national African American political, athletic, and media organizations as well as educational organizations and universities.

Establish trust between the health department and African American communities and CBOs

In light of the historical underpinnings previously discussed, there are a number of actions that health departments can take to gain the trust of African American communities and CBOs. A good place to start is to acknowledge

misrepresentation and mistreatment by the public health system in the past, talk with members of African American communities about the impact of historical underpinnings, and communicate about the impact of historical underpinnings, and communicate the willingness to move forward together with a spirit of respect, cooperation and positive change. Initially this may require the health department meeting the community more than half way. Keep in mind that it takes time to build trust and rushing the process can be counterproductive.

There are other concrete steps health departments can take to build trust. Holding relevant meetings at mutually agreed upon locations in the community, rather than at the health department offices is one such step. The parties may also want to bring in an outside facilitator in the early stages of the collaboration. If this is the case, both parties should jointly choose a facilitator with whom everyone feels comfortable. Establish mutually agreed upon ground rules and create norms that foster open and honest communication. Health department staff should speak in language that is accessible to the community, and design written materials that can be easily read by lay people. Identify mutually beneficial goals and set aside time for honest dialogue about what individuals think are the potential risks and benefits of the collaboration. This and other conversations may need to be revisited because the degree of honesty will grow as trust deepens.

Assist in establishing trust between African American CBOs and community members that are forging new partnerships

When health departments are facilitating a new collaboration between CBOs, they need to do so thoughtfully and with consideration. Emphasize that building coalitions and collaborations is about cultivating relationships towards the mutual exchange of resources and information. Establish ground rules that promote inclusion and value the differences that each party brings. Address the balance of power between collaborating agencies and develop a mutually agreed upon system of accountability.

Acknowledge differences in capacity, ability, and knowledge among members and take time for partners to mutually agree upon goals, objectives, roles and responsibilities. Together, the partners should establish rules for decision-making and identify a contingency plan in the event of a stalemate. Acknowledge that historic underpinnings may cause groups to proceed cautiously, and validate that people are coming together to move forward and make a positive impact on the community.

Health departments should also acknowledge and address the different levels of coalition building going on in different jurisdictions and actively support the development of new coalitions across various sectors of the African American community, especially those at highest risk for HIV/AIDS (e.g., transgenders, MSM, IDUs, women and youth).

Foster and maintain African American leadership as board members and staff of CBOs and ASOs

Health departments should take an active role in mentoring and supporting African American leadership in African American AIDS organizations and in the larger ASOs and CBOs in their jurisdictions. Mentoring activities include board and staff development, offering coaching for executive directors, training on board recruitment, or providing dollars for CBOs to hire consultants to help them attract and retain highly talented individuals.

A visible, accessible presence of African American leadership in the health department is an important element for leadership development in the community. African American leaders in the health department can mentor upcoming leaders in the community, offer regular opportunities to gather for support, sponsor leadership development training programs and foster networking between leaders in the HIV and non-HIV communities.

***Foster coordination and collaboration within the health department itself**

There are many individual departments within the health department itself whose effectiveness in African American communities could be enhanced by coordinating efforts, sharing resources and collaborating. These units include, but are not limited to, maternal and child health, STD prevention and treatment, substance abuse prevention and treatment, juvenile justice, violence prevention and community health.

Program Implementation

Acknowledge historic underpinnings

Make sure all programs take into account the historical underpinnings that affect how African American's process health-related information and access health care. Service providers and health department staff should participate in cultural sensitivity, antiracism and diversity trainings that address difficult issues such as privilege, power, socioeconomic status, and discrimination based on race, gender, and sexual orientation. Such trainings must be carefully tailored to meet specific needs of health departments and comfort level of the participants.

Work with African American communities to establish standards of care

There are many points for improving standards of care and access to care in African American communities. These include providing early intervention services, promoting access to facilities that adhere to federal treatment guidelines, addressing unmet needs and implementing quality management. Standards must also focus on creative ways to keep African Americans in care, as norms of community mistrust reinforce the tendency to discontinue care.

Disparities exist for African Americans in all facets of health care -- prevention, primary care, mental health care and dental care to name a few. A holistic approach needs to be taken in which health departments engage stakeholders from all parts of the public health system and African American communities to address the health care disparities, particularly among those at highest risk for HIV.

Ensure the presence of culturally diverse staff to implement care and prevention programs

Culturally diverse staff should be present at the state and local levels. The presence of qualified African Americans and other staff of color help ensure that prevention and care programs are designed, implemented and evaluated through a culturally sensitive lens. Many African Americans may feel a degree of distrust towards treatments that are commonly accepted in other communities. This distrust is related to historical underpinnings and the fact that historically, treatment and care in African American communities has been less than adequate when compared to services in other communities.

***Support the implementation of reputable programs**

In light of the fact that there is a dearth of behavioral science research on African Americans and HIV/AIDS, health departments need to implement prevention and care programs that are high in quality and efficacy. This includes programs favored by the community for achieving positive outcomes despite lack of formal process or outcome evaluations.

Seek out capacity building assistance for the health department

Health departments and AIDS directors may consider seeking out assistance to build their own capacities, which in turn will allow them to be more effective in helping CBOs implement programs. Sources of capacity building assistance include health departments in neighboring states (allowing for the exchange of expertise and experience across health departments) and federal capacity building assistance programs. Capacity building within the health department can strengthen program implementation efforts by identifying and addressing gaps in service and responding to the needs of organizations reaching out to African American communities.

***Provide funding and capacity building assistance to CBOs for the evaluation of prevention and care programs**

As outlined in the federal guidances, prevention and care programs should be regularly evaluated for the purposes of quality management, and to identify areas in need of improvement. Evaluation data should also be used for designing new programs that are built on strategies shown to be effective.

***Provide seed money to encourage and fund community-based African American HIV/AIDS initiatives**

Identify agencies that are doing good work, but have never been funded to do HIV/AIDS work, and need to establish a track record to apply for larger funding. Pay special attention to those programs addressing the diverse needs of the highest risk populations within the African American communities.

Behavioral Research

***Identify opportunities for outcome evaluation**

Outcome evaluation focuses on the stated behavioral objectives of the program and should demonstrate that the program causes (or fails to cause) a specific change.

Outcome evaluation answers the questions “What worked?” “Did anything work?” “Why did one intervention work better than another?” Evaluations present opportunities to learn from successes and failures, and are often used to drive program design and future program funding. Outcome evaluation results can and should be shared with other agencies, organizations, and health departments.

Use culturally specific language when designing and implementing outcome evaluations

Standard language used in outcome evaluation may have to be modified to fit the varying cultural contexts in which service providers and community organizations work. The one-size-fits-all approach may diminish effectiveness or trust between communities and the health departments. For example, the meaning of “success” varies by culture. The challenge for prevention providers is to find indicators that are meaningful to the populations served, while still providing accountability.

***Include representatives from communities at highest risk in outcome evaluation design and implementation**

For these groups it would be risky to use standard approaches for developing and measuring outcomes. Organizations serving African American communities must be involved in evaluation design and have creative room to apply outcome evaluation concepts to their own communities.

In addition, including community leaders and peer workers in research activities can help create a greater social pressure to perform safer behaviors, help create positive emotional community response to programs, and help identify program participation with community members’ self image.

Support formative research as part of the program design process

Formative research must be done to determine which behavioral science theories and appropriate interventions drive HIV-prevention programs. African American communities cannot be approached as a monolithic entity. Therefore, health departments should incorporate time and funding for formative research to occur prior to the implementation of all programs. High-risk sub-groups within African American communities must be researched to understand their unique social norms, interventions that produce positive and negative emotional responses, barriers to performing safer behaviors, and the perceived benefits and disadvantages of performing safer behaviors. Traditional approaches have not had a satisfactory impact in stopping the spread of HIV in African American communities, and clearly more research needs to be done.

Understand the impact of historical underpinnings on African American communities

Many stereotypes have been used to describe African American communities, and program interventions have been developed based on these stereotypes. Historical underpinnings drive many negative attitudes African Americans have toward health departments and potentially effective public health measures. In order to engage a paradigm shift in how health departments view African American communities and how African American communities view public health departments, researchers must understand the impact of historical underpinnings on any research done in African American communities. Members from the targeted African American communities must be included in all phases of formative research.

***Promote linkages between CBOs and behavioral scientists**

Behavioral scientists represent the scientific establishment to African American communities via the public health departments. The CBOs represent African American communities to the behavioral scientists. Based on historical underpinnings this relationship is one of mistrust on one side and condescension on the other.

To change this relationship and address the imbalance of power, representatives from African American communities and CBOs must participate with behavioral scientists in all phases of behavioral research done within African American communities. To ensure successful and positive results from this participation, technical assistance in the form of training and mentoring may be necessary for community representatives. Simultaneously, technical assistance, training, and mentoring may be necessary for behavioral scientists with respect to understanding the historical underpinnings and the perspective of African American communities.

Create a Minority AIDS Coordinator position in each jurisdiction

A Minority AIDS Coordinator position should be created in jurisdictions with high African American HIV/AIDS incidence rates and/or large African American populations. Such a position would ensure African American participation in research efforts and the cultural relevance of all research information and processes.

Include African American community leaders and peer workers in outcome evaluation design and implementation

Within African American communities, education and prevention efforts must be directed at changing community-wide norms, promoting economic opportunity and social stability. The inclusion of community leaders and peer workers in research activities can help create a greater social pressure to perform safer behaviors, help create positive emotional community response to programs, and help identify program participation with community members' self images.

Include health department performance in the program evaluation process

Community trust, power balance, and program effectiveness can all be improved if health department performance is also included in the program evaluation process.

Appendix 2

Self-Assessment Tool

NASTAD developed this self-assessment tool to help facilitate health departments' implementation of the monograph recommendations. The tool is organized into three parts—anticipated level of difficulty, baseline assessment, and post assessment. Because the tool is qualitative in nature, there will be a level of subjectivity based on those making the assessment. Therefore, NASTAD suggests that a group of health department staff and a representative set of stakeholders conduct the assessments collaboratively.

Anticipated level of difficulty is designed to help health departments assess the challenges it may encounter in implementing the recommendation. By taking the time at the outset to identify potential challenges, health departments can proactively create strategies to manage or mitigate difficulties in order to increase likelihood of success. The baseline assessment is important because it provides a point of comparison to assess progress after three to five years. The post-implementation assessment offers a means to gauge progress against the baseline. The information will help organizations discover if they are taking the actions required to achieve the desired outcomes.

Assessing Anticipated Level of Difficulty

A representative group should assess each recommendation and determine how difficult it will be to implement it using the following criteria:

- **Difficult** – likely to encounter significant resistance and distrust and have insufficient financial and human resources.
- **Manageable** – can anticipate the typical challenges associated with implementation of recommendations or organizational and programmatic changes.
- **Easy** – should be easily received with adequate financial and human resources.

Scoring the Baseline and Post-Implementation Assessments

The intent of the baseline and post-implementation assessments is to gauge progress the organization has made. For each recommendation assign a value of 1, 3, or 5.

- 1 = Not started, no work has been made in this area
- 3 = In process
- 5 = Completed

Total the scores and divide the total by 31, the total number of recommendations. The resulting average provides an indicator of the extent to which progress has been made and recommendations implemented. An average of 3.5 to 5 suggests significant progress. An average of 2.5 to 3.5 suggests movement and some progress. An organization scoring below 2.5 may need to reassess, reprioritize, and/or identify additional resources.

Why we can't wait:

To identify areas of strength and opportunities for improvement, average the ratings within a cluster of recommendations.

Recommendation (from 2001 monograph – see Appendix 1 for full listing of recommendations)	Anticipated Level of Difficulty	Baseline Assessment	Post Implementation Assessment
Epidemiological Perspectives			
1 Convene an African American HIV epidemiology work group			
2 Utilize epidemiological data to inform ongoing dialogue and planning of HIV prevention and care services			
3 Fund and support efforts to increase the participation of African Americans in the field of epidemiology and behavioral science			
Capacity Building (within health departments)			
1 Take a top down approach			
2 Consider multiple sources for obtaining capacity building in health departments			
3 Conduct an assessment of cultural competency of the health department (and/or the AIDS office within the health department)			
4 Offer educational workshops to health department managers and staff on the historical dynamics between racism, African Americans, HIV/AIDS and the public health system			
5 Offer management development training with a focus on cultural competency			
6 Create a Minority AIDS Coordinator position in health departments serving jurisdictions with large African American populations			

The Tipping Point for HIV/AIDS Among African Americans

Recommendation (from 2001 monograph – see Appendix 1 for full listing of recommendations)	Anticipated Level of Difficulty	Baseline Assessment	Post Implementation Assessment
Coalition and Partnership Building			
1 Be aware of the traditional mistakes that health departments make when helping CBOs build collaborations			
2 Build coalitions and partnerships with stakeholders who represent a broad range of African American constituencies			
3 Establish trust between the health department and African American communities and CBOs			
4 Assist in establishing trust between African American CBOs and community members that are forging new partnerships			
5 Foster and maintain African American leadership as board members and staff of CBOs and AIDS Serving Organizations			
6 Foster coordination and collaboration within the health department itself			
Program Implementation			
1 Acknowledge historic underpinnings			
2 Work with African American communities to establish standards of care			
3 Ensure the presence of culturally diverse staff to implement care and prevention programs			
4 Support the implementation of reputable programs			
5 Seek out capacity building assistance for the health department			
6 Provide funding and capacity building assistance to CBOs for the evaluation of prevention and care programs			
7 Provide seed money to encourage and fund community-based African American HIV/AIDS initiatives			

Why we can't wait:

Recommendation (from 2001 monograph – see Appendix 1 for full listing of recommendations)	Anticipated Level of Difficulty	Baseline Assessment	Post Implementation Assessment
Behavioral Research			
1 Identify opportunities for outcome evaluation			
2 Use culturally specific language when designing and implementing outcome evaluations			
3 Include representatives from communities at highest risk in outcome evaluation design and implementation			
4 Support formative research as part of the program design process			
5 Understand the impact of historical underpinnings on African American communities			
6 Promote linkages between CBOs and behavioral scientists			
7 Create a Minority AIDS Coordinator position in each jurisdiction			
8 Include African American community leaders and peer workers in outcome evaluation design and implementation			
9 Include health department performance in the program evaluation process			
Total	NA		
Total divided by 31	NA		

Appendix 3

Other Successful Strategies

California

Project Title: Statewide African American HIV/AIDS Initiative

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Objectives of Strategy

The Statewide African American HIV/AIDS Initiative was enacted via State Assembly Bill 1142 and is administered through the California Department of Health Services Office of AIDS (DHS/OA). The initiative addresses the disproportionate impact of HIV/AIDS on African Americans. The bill sponsorship included collaborations between the Statewide African American HIV/AIDS Advisory Board, the California Conference of the National Association for the Advancement of Colored People, and bill author Mervyn Dymally, a California State Assemblyman. Language cited from the one-of-a kind legislation is as follows: "There is hereby established the Statewide African American Initiative to address the disproportionate impact of HIV/AIDS on the health of African Americans," (California AA HIV/AIDS Initiative 2006-2008).

The African American HIV/AIDS Initiative employs six objectives:

- Establish the Statewide African American HIV/AIDS Initiative in statute to address the disproportionate impact of HIV/AIDS on the health of African Americans by coordinating prevention and service networks around the state. It will further establish the administrative, educational, and communication infrastructure, including personnel, facilities, and technology, to support the activities of the provider network.
- Mandate that DHS/OA provides initial administrative support for the core functions of the Initiative until January 1, 2008, when the Initiative would become an independent non-profit organization.
- Implement the Initiative in five designated regions: 1) Alameda/San Francisco; 2) Los Angeles; 3) Sacramento/Central Valley; 4) San Bernardino/Riverside; and 5) San Diego.
- Design and conduct projects focusing on research, policy and advocacy, workforce development, organizational capacity, and prevention and treatment information and resources; provide leadership in sustaining partnerships with stakeholders; and improve the efficacy of local service providers through a central coordinating body.
- Mandate that DHS/OA appoint an internal advisory committee that includes the African American HIV/AIDS Specialist, an OA section head, and a designee to supervise day-to-day activities.
- Require the establishment of a Statewide African American HIV/AIDS Advisory Board DHS/OA that is comprised of its current membership.

Approach

The initiative is an effort focused on policy, organizational capacity, workforce development, research, and evaluation, rather than on direct service provision. The initiative is a vital mechanism to provide leadership development, technical assistance, and coalition building in five distinct regions in the state of California to address health disparities among African Americans related to HIV/AIDS.

Challenges

- Providing leadership that has the ability to bring about collaboration within the regions and throughout the state;
- Standardizing the work of the regional coalitions since they have differing needs and are in different phases of development;
- Building strong and effective collaboration between state health agencies, community-based organizations and community stakeholders;
- Convincing existing community-based organizations that capacity building is essential in providing more effective and efficient HIV services.

Results

- A validated plan indicating the support and commitment of community leaders and public-policy makers to take action;
- Twelve goals were developed after a year of statewide planning that culminated into the statewide advocacy summit with 130 participants in attendance;
- A Statewide Planning Summit convened in October 2003 to develop the Statewide African American HIV/AIDS Initiative;
- Convened a Follow up African American and HIV AIDS Summit specific to policy and Research, March 2004;
- Convened a follow up Statewide African American and HIV/AIDS Summit in October 2004;
- Ongoing support and development of five regional coalitions in 1) Alameda/San Francisco, 2) Los Angeles 3) Sacramento/Central Valley 4) San Bernardino/Riverside and 5) San Diego.
- Developed infrastructure, governance model, bylaws, values, goals, and objectives of the Statewide African American HIV/AIDS Advisory Board (May 2005).

Way Forward

- Establish the view that an initiative of this type can be a conduit to bringing communities at risk and of color out of health care depression;
- Develop a packet that outlines the depth of the problem, the history of the initiative and the bill, and the intended goals;
- Provide background on both the national and statewide perspectives such as facts and statistics;
- Convene well-organized and intentioned initial planning meetings or summits;
- Establish, where feasible, a process whereby the initiative does not compete with existing community-based organizations but rather strengthens their service capacity;
- Provide readily available tasks for the steering committee and have a broad representative base present including community based organizations, research institutions, and state, county, and city health officials;
- Factor in specific phases within the developmental process and gauge success regularly;
- Create and utilize a statewide resource network to coordinate specific tasks and oversight functions; and
- Consider administrative and infrastructure supports necessary to accomplish a major initiative of this type.

Resources

- Fact Sheet. California Department of Health Services, Office of AIDS, Statewide African American HIV/AIDS Initiative.
- California African American HIV/AIDS Initiative (2006-2008).

Florida

Project Description: Silence is Death: The Crisis of HIV/AIDS in Florida's Black Communities

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Objectives of Strategy

The analysis in the report focuses on persons living with a diagnosed, reported case of HIV/AIDS (PLWH/A) in the 20 Florida counties with a total of at least 600 PLWH/A through 2005. The report uses PLWH/A data as a catalyst to mobilize a comprehensive response to the HIV/AIDS crisis among Blacks. The report encourages local communities to take ownership of the disease and get educated, tested, and involved. The document seeks to:

- Break the silence by raising awareness about HIV/AIDS among Blacks;
- Encourage local governments and communities to expand and strengthen their responses to the HIV/AIDS epidemic among Blacks;
- Encourage individuals to be tested for HIV/AIDS;
- Increase access to HIV prevention and care services;
- Reduce barriers to HIV testing, prevention, and care by reducing HIV/AIDS stigma; and
- Stimulate the development of a plan to address the disproportionate impact that HIV/AIDS is having on Black communities.

The Florida Department of Health believes that fighting the spread of HIV/AIDS and reducing the burden of HIV/AIDS among Blacks will require a comprehensive approach to improve prevention, testing, and treatment programs in our communities. The Department needs the community's help to mobilize efforts to combat this HIV/AIDS crisis, and to coordinate these initiatives with political and religious leaders, civic organizations, businesses, schools, parents, cultural leaders, and PLWH/A in a coordinated campaign of advocacy and action.

Approach

In 2005, for the first time, the Florida Department of Health, Bureau of HIV/AIDS analyzed its HIV/AIDS prevalence rate data by county and race/ethnicity and organized it by ranking the counties for each race. The PLWH/A data for the top 20 counties are presented in rank order so that the experience of each county can be put in perspective with the others, facilitating the targeting and prioritization of efforts to close the gaps. The report presented the data in raw

numbers of cases, "1-in statements, rates, and rate ratios in order to quantify disparities.

The data in the report was put in the perspective of underlying factors and root causes of HIV/AIDS in order to minimize HIV/AIDS stigma among Blacks. After receiving comments, the data was minimally revised in order to effectively communicate it to the most impacted groups.

Recommendations were included in the document to assist political and religious leaders, civic organizations, businesses, schools, parents, cultural leaders, and PLWH/A to reduce HIV/AIDS disparities.

To get the attention of the Black community and the media, the department issued a press release highlighting the report. In the press release the Department of Health Secretary, M. Rony François, M.D., M.S.P.H., Ph.D, stated, "It is unacceptable that for 15 years in a row, HIV/AIDS has been the leading cause of death among black Floridians aged 25-44 years...It is time for us to mobilize communities and all those who have a stake in the epidemic to find innovative ways to reduce the associated morbidity and mortality."

More than 5,000 copies of the report have been disseminated to county health departments, at conferences, to community members, and through various organization requests since its release in September 2006. The report was given to all 67 county health directors/administrators, HIV/AIDS Program Coordinators, STD Program Managers, the Director of the Minority Health Office, federal partners, the National Association for the Advancement of Colored People, community members, the Secretary of the Department of Health, the Governor, NASTAD, and CDC. The report was distributed at several community mobilization and strategic planning meetings.

Community mobilization and strategic planning meetings were held with county health departments (CHD), partnering organizations, and individuals from the community to further discuss the report. We encouraged them to form community coalitions, composed of CHD staff and community-based-organizations, as well as concerned individuals. During the meetings, community members assisted in the implementation of community action steps to address the HIV/AIDS disparities among Blacks.

The bureau later identified key indicators and established targets for reducing cases and deaths among Blacks.

Challenges

The obvious key challenge was encouraging counties and community leaders to increase their HIV prevention efforts without additional funding. Although this is an unfunded mandate for local communities and county health departments, individuals and organizations have rallied behind this initiative to encourage individuals to get educated, tested, and involved.

Results

- Conducted strategic planning meetings with Palm Beach, St. Lucie, Miami-Dade, Collier, Lee, and Sarasota county health department staff and selected community-based organization staff.
- Conducted community mobilization meetings in Palm Beach, St. Lucie, Orange, Volusia, Broward, Leon, Duval, and Alachua counties.
- Convened bi-monthly calls to address action steps within the report.
- Formed Community HIV/AIDS coalitions in Palm Beach and St. Lucie Counties. The coalitions are committed to working with the local county health department.
- Placed Silence is Death billboards in St. Lucie, Palm Beach, and Miami-Dade counties.
- The report was downloaded from the Bureau of HIV/AIDS website 1,286 times in September 2006 and 554 times in October 2006.

- Comparing August 2006 to September 2006, the number of visitors to the Bureau's prevention website, WeMakeTheChange.com, increased 26 percent, the number of hits per day increased 46 percent and the average length of time spent on the site increased from five to 18 minutes.
- The CDC has had communications and a conference call with the Department of Health (DOH) Bureau of HIV/AIDS Program staff to further partner with Florida on activities and initiatives following the report.

Lessons Learned

- Established a county health department work group that consists of health directors and other staff.
- Established an internal work group that consists of staff from numerous DOH offices: AIDS, STD, Family Health, and Office of Minority Health.
- Area work plans were developed to address the implementation and recommendations of the report.
- Coalitions and networks were established in areas to assist with community mobilizations efforts.
- The Bureau of HIV/AIDS developed a Share Point website to highlight Silence is Death initiatives and to share best practices, successful strategies, and lessons learned.
http://www.doh.state.fl.us/disease_ctrl/aids/index.html

Illinois

Project Title: The African American HIV/AIDS Response Act

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Description

The African American HIV/AIDS Response Act was championed by Illinois State Representative Constance Howard and State Senator Kimberly A. Lightford as a comprehensive plan to address HIV/AIDS in the state of Illinois. The Act successfully transitioned into The Illinois African American HIV/AIDS Response Fund (IAAHARF) orchestrated by the Illinois General Assembly in 2006. The Act makes available HIV testing in high traffic offices run by the state of Illinois, assists welfare recipients, and explores the intersection of HIV and corrections.

The overall mission of the fund is to provide Illinois African American communities with necessary resources to create a HIV/AIDS service delivery system that reduces disparity of HIV infection and AIDS cases between African Americans and other communities.

Objectives of Strategy

The IAAHARF incorporated the following major directives:

- A comprehensive culturally and socially-competent HIV Prevention Plan for the Illinois African American communities;
- A state-wide testing program that by year 10 would result in one million Illinois citizens tested for HIV annually;
- Development of a stable infrastructure within African American communities;
- Permanent funding provided for the HIV/AIDS Policy and Research Institute at Chicago State University to expand and support necessary research;
- Comprehensive technical and capacity building assistance to African American AIDS service organizations; and
- The creation and sustainability of at least 17 and up to 20 one-stop-shopping HIV/AIDS facilities across the state.

Approach

In order to accomplish the directives, funds were earmarked for corrections and HIV testing in jails. Strategies for goal attainment included appointment of a nine-member panel to review the implementation of the African American HIV/AIDS Response Act and Fund. A second strategy included a study coordinated by The Chicago State University HIV/AIDS Policy and Research Institute to determine the correlation between incarceration and HIV infection. Other major points of interest included:

- Increased availability of HIV testing;
- Created African American HIV/AIDS Response Officers;
- Permitted Medicaid waivers and modified welfare-to-work participation.
- Web site materials available focusing on HIV prevention and education targeting current or former inmates;
- Entitlements to testing, care, and services for juvenile and adult Illinois Department of Corrections (IDOC) inmates;

The Tipping Point for HIV/AIDS Among African Americans

- Transitional case management including referrals to support services for HIV-positive inmates before release;
- Information for visitors to include culturally-sensitive written materials on HIV/AIDS and counseling; and
- HIV testing provision for county jails including Cook County and others.

Challenges

- One of the greatest challenges has been the response of organizations. While all organizations support the effort the issues of when and how funds will be distributed has caused some consternation among African American service providers.
- The construction of the fund made it necessary for additional administrative rules to be crafted. As a result, the first year's funding has not become available for distribution. While this will cease to be a challenge in subsequent years, this year it will serve as a barrier.

Results

It is too early in the process to ascertain the ultimate results of the Act and the Fund. However, close monitoring and evaluation of grantee performance will provide examinable data for the future.

Lessons Learned

- Organize community advocates in advance of promulgating the legislation. This would secure buy-in early in the process and avoid dissension when funding becomes available.
- Care should be taken in crafting the document so that legislative language does not impede operational performance of the task.

Resources

Fact Sheet. The African American HIV/AIDS Response Act produced by Let's Talk, Let's Test Foundation

Louisiana

Project Description: Collaborations and Partnerships post-Katrina in the New Orleans area

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Objectives of Strategy

- To re-map the outreach areas Post-Hurricane Katrina in high-risk areas with a large concentration of African Americans which faced difficulty with accessing prevention resources and care.
- To assess what services (prevention, substance abuse, mental health, etc.) still existed post-Hurricane Katrina; and
- To assess the staffing issues/shortages with both health department and contractors in order to re-start prevention activities post-Hurricane Katrina.

Approach

- Met with each contractor to discuss contingency plans;
- Met with contractors weekly to discuss best strategies for re-starting prevention activities in high-risk areas where African American social networks congregated.
- Canvassed the high-risk areas for African-American gatekeepers to assist outreach teams with information concerning population shifts and high-risk activities in targeted areas
- Conducted area assessments in high-risk neighborhoods by retrieving data such as demographics, inventory of operable businesses and medical services; and identifying hot spots for high-risk activities such as Intravenous drug use and unprotected sex.
- Formed Region 1 Outreach Team (Jefferson Parish and Orleans Parish), due to staff shortages and devastation of areas. The Region 1 Team consists of five community based organizations (Camp Ace, NO/AIDS Task Force, Jefferson Parish Human Services Agency, NR PEACE, Drop In Center); and
- Met on a monthly basis to discuss prevention activities and devise the calendar for following month.

Challenges

- New staff-unfamiliar with outreach procedure and protocol
- Staff shortages-in most cases contractors were forced to wear multiple hats
- Devastation of some communities and areas
- Had to get re-introduced to the community remaining
- Influx of Spanish speaking migrant workers
- Dearth of STD clinics, reproductive health services
- Increase in violence
- CBOs were territorial

The Tipping Point for HIV/AIDS Among African Americans

- The face of the community had changed
- Language barriers
- Cultural barriers
- New homeless

Results

- Over time, in some cases, seasoned veteran workers were able to return
- Mapping training
- Health units became primary source of referrals for the underinsured
- Hiring of Latino outreach workers that teamed up with African-American outreach workers
- Slowly, clinics re-opened
- CBOs began combining their resources in order to achieve results
- Prevention messages are holistic and client centered
- “Non-traditional outreach efforts” such as collaborating with other regions since the population had shifted across the state
- Formed collaborations with other Public Health entities (Family Planning, TB, STD, etc)

Way Forward

- Tailor prevention messages so that they are holistic. (e.g. referrals now include mental health, housing, FEMA, legal help)
- Continue monthly meetings (issues that may arise can be addressed quickly)
- Constant flow of trainings (outreach, CT, PCRS, and cultural competency trainings)
- Maintain state-wide collaborations

Maryland

Project Description: *Pharaoh*, a new intervention for heterosexual African American men with a history of incarceration

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Objectives of Strategy

- Reframe/recast constructs of black masculinity to emphasize responsibility to self and to others; and
- Reduce the transmission of HIV among African American heterosexuals.

Approach

Heterosexual men have been an under-researched and underserved target of HIV prevention efforts. African Americans are highly disproportionately affected by HIV/AIDS in Maryland. Therefore, the AIDS Administration collaborated with the University of Maryland, School of Social Work, in the design and development of a new HIV prevention intervention (*Pharaoh*) which targets heterosexual African American men.

Pharaoh is a multi-session intervention for groups of eight to 12 African-American men with a history of incarceration. Maryland is currently delivering *Pharaoh* in correctional, transitional housing, and in-patient drug treatment settings. *Pharaoh* consists of five two-hour sessions covering the following topics: ethnic/gender pride, responsibility and empowerment, HIV prevention education, condom skills and self-efficacy, and transitioning into the community. *Pharaoh* explores with men their responsible use of power.

The curriculum leads participants in re-evaluating personal values and beliefs about manhood, recalling positive male role models of African descent, and planning to follow these role model examples in risk reduction decision-making. *Pharaoh* incorporates Social Cognitive practices that involve the participants in role-plays, discussions, and activities. All of these exercises address substance abuse, HIV, and other risk situations that may arise once the participant is released back into the community. *Pharaoh* teaches how the virus is transmitted, how to protect oneself, and how to communicate with sex and/or needle sharing partners about protecting each other.

Challenges

There have been two primary challenges to implementing *Pharaoh*. The first has been establishing and maintaining curricular fidelity. There is no national rigorously-evaluated and recommended intervention for this population. Local agencies embraced *Pharaoh* to address a considerable range of unmet programmatic needs. In some instances this has involved interpretation and adaptation of the curriculum to specific venues or to subpopulations of heterosexual men. The state health department closely observed the early implementation of the intervention and considered facilitator experiences in drafting the subsequent iteration of *Pharaoh*. Given the early fluidity of the intervention, it has been a recent challenge to achieve implementation of a consistent, standard *Pharaoh* curriculum.

The second challenge has been the retention of incarcerated participants across all five sessions of the intervention. This challenge results not from participants' lack of interest, but rather from the unpredictability of the incarcerated setting: inmates' release dates and court dates are frequently subject to change and participants may be discharged or relocated prior to completing all sessions. *Pharaoh* sessions may also be abruptly terminated or canceled due to lock-downs and other events in these venues.

Results

An analysis of more than 700 matched pre-post tests indicate that the *Pharaoh* curriculum is partially successful in addressing factors that impact risk behaviors among incarcerated heterosexual men. *Pharaoh* participants showed significantly greater intentions to use condoms during both vaginal and anal sex, reported feeling significantly less likely to trade drugs for sex with a woman after release from incarceration, indicated feeling a greater obligation to live a healthy lifestyle, indicated greater self-efficacy in dealing with stress and pressure to use drugs after release, and showed a decreased tolerance for risk. Knowledge of HIV transmission methods and risks significantly increased as well. However, perceived risk of contracting HIV remained unchanged after the program.

The results also provide evidence of dosage effects, in that those with at least eight hours of intervention showed more success in achieving the stated objectives than those who received fewer than eight hours of intervention. This finding indicates the importance of ensuring that as many participants as possible are able to complete the full intervention.

The limitations of this analysis include the following: the curriculum is new and is implemented in diverse sites across the state of Maryland. Therefore, facilitators took liberty in modifying the curriculum to meet their population's specific needs. Such variation means that it is likely that not all participants received the exactly the same content. Additionally, the results are limited by the challenge of administering written pre- and post-tests within incarcerated settings where participants might self-censor reporting behaviors, attitudes, and beliefs.

Lessons Learned

To be successful with *Pharaoh*, a jurisdiction would need:

- Buy-in from the local correctional facilities housing African-American men, including:
 - Facility approval for frank discussions about sexuality and HIV prevention;
 - Facility consent to provide space and client time for participation in *Pharaoh* sessions.
- African-American male leaders with counseling and group facilitation skills/training.

Maryland

Project Description: *RISE* (Rewriting Inner Scripts), a new intervention for African American same-gender-loving men

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Objectives of Strategy

- Raise the consciousness of African-American men who have sex with men (AAMSM) about internalized oppression and its personal impact;
- Increase AAMSM utilization of MSM health programs including HIV prevention, HIV counseling and testing, HIV care, substance abuse, and mental health services; and
- Reduce the transmission of HIV among AAMSM.

Approach

RISE is a full-day retreat for groups of ten AAMSM. *RISE* is offered on Saturdays at The Portal/Empowering New Concepts, Baltimore's African-American GLBT Community Center. *RISE* retreats are facilitated by self-identified AAMSM. Half the day's activities identify the sources of internalized oppression in the dimensions of race, gender, and sexual orientation. The balance of the day involves reframing and rebuilding exercises that empower participants to interrupt negative self-talk and reframe internal decisions. The retreat concludes with the distribution of a local MSM Resource Guide, including referrals to MSM-friendly HIV care providers. *RISE* participants are offered a motivational interview as follow-up, in which counselors attempt to address and assist the client in overcoming barriers to their enrollment in other programs.

The premise of *RISE* is that providers' expectations of health-seeking behaviors are not realistic for some members of highly oppressed communities. Health-seeking behaviors result when individuals place value on their own health and exert effort or incur costs on its behalf. Some same-gender-loving African American men have been so impacted by oppression that they do not value themselves enough to participate in health programs such as HIV prevention and treatment, substance abuse, and mental health. *RISE* explores the shame associated with being gay. *RISE* helps participants to perceive that their sexual orientation does not make them a failure. Rather, others have failed to value their sexual orientation. *RISE* intends that after they achieve this shift in perspective, participants will be more self-accepting and better prepared to perceive health-seeking behaviors as meaningful.

RISE is the hub through which clients pass on their way to other health programs. As part of a framework of linked services for AAMSM in Baltimore, all state health department-funded MSM projects are required to capture, at intake, the route by which MSM entered the project. Successful referral completions are counted and communicated at quarterly meetings of the MSM Response Team, which is comprised of funded MSM service providers and other stakeholders.

RISE Plus combines *RISE* and a second retreat for the same group of men on the following Saturday. *RISE Plus* builds on the foundation of *RISE* and explores the consequences of inner scripts on relationships, including the following: sex partner selection, relationship norms, substance abuse, and HIV risk behaviors. Whereas *RISE* is designed as a bridge into other health services, *RISE Plus* is designed as a stand-alone HIV prevention intervention.

Challenges

There have been two primary challenges to implementing *RISE* and *RISE Plus*. The first has been the limited number of self-identified same-gender-loving African American men with strong group facilitation skills. Because these curricula are significantly informed by the Social Learning Theory, the facilitators must be AAMSM. However, the few eligible facilitators are typically already involved in the delivery of other important community interventions.

The second challenge has been a disconnect between the program design and participants' preferences. The program intends to "graduate" *RISE* participants into other health services, while the participants wanted to attend the *RISE* retreat repeatedly.

Results

RISE and *RISE Plus* are brand new. *RISE* was piloted in early 2006 and just began to be offered monthly as of October. The first *RISE Plus* is expected to occur in January 2007. Early evaluation findings suggest that participants experience *RISE* as highly beneficial. In the post-tests collected to date, there are high levels of participant agreement with the statements, "After attending this Retreat, I am determined to be more accepting of myself," "After attending this Retreat, I am more likely to access health and other services (e.g. HIV testing, HIV care, mental health, drug treatment)," and "Would you recommend this program to others?"

Lessons Learned

To be successful with *RISE* and/or *RISE Plus*, a jurisdiction would need:

- An appropriate site:
 - at which African-American, same-gender-loving men feel comfortable assembling;
 - at which food can be served;
 - (preferably) at which mental health services are also available.
- Self-identified same-gender-loving, African-American male leaders with counseling and group facilitation skills/training.
- A commitment to collaboration among MSM service providers.
- A mechanism for tracking referrals among MSM service providers.

Minnesota

Project Title: Project Ujima

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Description

The Minneapolis-St. Paul metropolitan area was designated by the Federal government as a relocation community for HIV-positive refugees, mainly from Africa, in the fall of 2001. As a result, there were significant increases of HIV infection in the African refugee communities, and, in the fall of 2001, Minnesota Department of Health (MDH) HIV epidemiological data indicated an increase in the number of HIV-positive African refugees in Minnesota. Simultaneously, the Minnesota Department of Human Services (DHS) and Hennepin County Community Health Department (CHD) began to see more HIV-positive African refugees in their various service programs. The two state agencies and Hennepin County, with considerable assistance from the African communities in Minnesota, mobilized to address this new challenge.

Minnesota is currently home to the tenth largest African-born population in the country and the second largest East African population and continuously experiencing an increasingly diverse HIV epidemic. While Africans made up less than one percent of the overall population in Minnesota, 21 percent of the total infections in 2002 and 2003 were among African born individuals. In the same year, half of all new diagnoses among women happened among African-born women.

Due to cultural and linguistic barriers, strong stigma, and denial, refugees in the African communities were at high risk for not receiving the ongoing HIV services they need. These include: 1) African communities continue to have a strong cultural bias against people living with HIV/AIDS and the stigma of HIV/AIDS is much higher in African communities; 2) HIV-positive refugees lack confidence in mainstream HIV service providers and case managers; and 3) HIV-positive individuals from the African communities do not trust the confidentiality of health care service providers.

To address these challenges, the Minnesota DHS HIV/AIDS Division applied for Health Resources and Services Administration's Office of Performance Review (ORR) grant for refugees with special needs to help African refugees with HIV/AIDS access the health care system, to improve the quality of life for refugees, and to access preventive and primary health care. The funds have been made available to provide extended resettlement services to newly arriving African refugees with HIV/AIDS. The grant was written, submitted, and awarded in September 2002.

The Tipping Point for HIV/AIDS Among African Americans

Objectives of strategy

After the major change in new infections was brought to light, it was clear that Minnesota needed to address the needs of this emerging community. The following departments within the state, Health, Human Services and Office of Refugee Resettlement, along with volunteer organizations, assisted in the relocation of these refugees and began to meet in order to address their emerging needs. Key issues included:

- Access to care;
- Prevention;
- Intervention;
- Capacity building;
- Culturally-specific case management;
- Documents in cultural language; and
- Secondary immigrations of PLWH/A.

Approach

The primary goal of Project Ujima was to improve the access of HIV-positive refugees to mainstream services by providing a culturally and linguistically-competent mainstream HIV case manager and by providing culturally-sensitive diversity training to other mainstream service providers. The secondary project goal was to improve access of HIV-positive refugees to support in their own communities through an education and awareness campaign, designed in partnership with the communities.

The project was limited in scope to only three East African communities: refugees from Somalia, Ethiopia, and Oromia. As an exploratory effort, the project was restricted to three groups in order to concentrate on speakers of three prevalent languages: Amharic, Oromo, and Somali.

Minnesota Department of Human Services hired Redwan Hamza as the project manager and Ama Sabah as an outreach specialist for African communities. Amin Umer, an experienced HIV/AIDS case manager who speaks the three East African languages, was selected by Hennepin County Medical Center (HCMC) to provide mainstream case management services to HIV-positive refugees. Wynfred Russell, an African and a professor of African and African-American studies at the University of Minnesota, was contracted to develop a curriculum specific to case managers working with African-born HIV/AIDS clients. All four bring extensive knowledge of community resources, the human service and health networks, as well as cultural and linguistic expertise.

Challenges

A limited English-proficient refugee faces a number of barriers to receiving primary HIV/AIDS care services. Language barriers, cultural barriers, and the social stigma have made this project's case management position invaluable to the HCMC HIV/AIDS Program. At intake, the case manager explains to clients the boundaries as a professional case manager and the foundations of trust and confidentiality between them. So as not to imply HIV status by association, the culturally-specific case manager purposely keeps a low professional profile within the African community. However, the issue of mistrust remains.

Language barriers and social stigma have the largest impact on the delivery of effective medical care to this population. HCMC incorporates interpreter services into medical care for limited English-proficient patients. While this practice addresses a language barrier to medical care, it has also created a confidentiality issue for an African immigrant patient concerned with stigma. Often a patient can feel exposed by having a member of his/her community (interpreter) in a medical setting where their HIV status might be revealed. Some patients refused hospital interpreters relying on family members. This also has created difficulties for the medical team knowing that inaccurate interpretation is occurring as well as potentially exposing the patient to stigma within their own family. Recent hospital budget cuts also have severely affected interpreter services for smaller language communities.

Results

While the HCMC Infectious Disease Clinic sees more than 1,000 patients annually, clinic social workers refer about 170 clients to the case management program; these are persons who need more intense and on-going social service connection. Regions Hospital in St. Paul also provides services to large number of refugees and immigrants from Africa. Today HCMC's program serves 140 African refugees and immigrant patients (163 unduplicated in last three years) or roughly 15 percent of the total clinic population. Substantial portions of this population are limited-English-proficient with Oromo, Amharic, and Somali being the predominant language groups represented. ORR funding has enabled this underserved population to receive culturally-appropriate health care and social services critical to their health, well being and successful integration into the American society.

The Case Management Program at HCMC has successfully addressed a number of cultural barriers that reduce the ability of the limited English-proficient African refugee population to receive effective HIV/AIDS medical services. Some of the barriers include: building trust with service providers, facing a highly stigmatized disease and becoming part of a stigmatized population, language barriers and the shortage of interpreters, confidentiality of interpreters, understanding complicated medication regimens, and educating clients about often confusing medical and insurance systems. The ORR-funded African Refugee case manager is versed in these issues and is not only successfully serving his case load of 30 "high needs" limited English-proficient clients but educating the other case managers and clinic staff on these same issues.

Way Forward

It is vitally important to continue the work started in East African communities and extend to other African communities the resources to:

- Increase the use of integrated primary and preventive health care and access to services to African refugees with HIV/AIDS
- Contribute to the achievement of community efforts to create HIV/AIDS awareness and education;
- Increase resources dedicated to the health sector, particularly primary and preventive health care services;
- Increase access to HIV/AIDS care services;
- Enhance capacity for African refugees to expand the use of HIV/AIDS services in response to the epidemic;
- Develop the capacity of the affected refugee communities through training and counterpart technical assistance;
- Provide technical assistance for an action plan by which refugee communities can implement strategies;
- Conduct community forums on key topics such as strategies to create awareness and community's willingness and ability to share their resources through workshops and publications.

Nebraska

Project Title: The North Branch Health Coalition (Nebraska)

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Objectives of Strategy

In 2004, a county health official presented information to community leaders regarding an increased number of sexually transmitted diseases (STD) in the Omaha metropolitan area. The predominant impact was among the African American community, specifically within the age range of 15 – 24 years. As a direct result of this information, the 100 Black Men of Omaha Health Committee convened a group of key stakeholders from the African American community, local and state public health officials, as well as elected officials and federal health partners from the CDC.

Goal 1: To provide a network of prevention, treatment, and care client services in HIV, STDs, TB, and substance abuse among African American populations in the North Omaha Community.

Goal 2: To develop and support service capacity of coalition partners throughout the North Omaha community.

Goal 3: To help reduce health disparities for African American populations within the North Omaha community.

Vision and Mission of NBHC

Vision: "A strong community-wide coalition working to make an impact on the rates of HIV, STDs, TB, and substance abuse."

Mission Statement: To reduce the incidence and spread of HIV, STDs, TB, and substance abuse among African American populations in the North Omaha community.

Approach

The approach implemented to support and build the coalition was spearheaded by Mr. Ramon Henderson, the chair of the 100 Black Men of Omaha Health Committee. He enlisted the assistance of local, state, and federal public health partners to convene a group of elected officials and key stakeholders in the community to address the issue of disparate STD infections. The slate of agency collaborators participating in the coalition:

- 100 Black Men of Omaha (Lead agency)
- American Red Cross
- BJ Nellum
- Black Family Health and Wellness Association
- Center for Holistic Development
- Charles Drew Health Center
- Douglas County Health Department
- Nebraska AIDS Project, Inc. (Co-lead agency)
- Nebraska Health and Human Services HIV Program

- Omaha Healthy Start
- Omaha Metropolitan YMCA
- Peoples Community Health Center
- The Coalition met monthly. There were several running committees:
 - Strengths, Weaknesses, Opportunities, Threats (S.W.O.T.) Committee
 - Governance Committee
 - Events Committee
 - Grants Committee
 - Social Marketing Committee

Challenges

- Lingering anger regarding the presentation of the data
- Sustainability of the Coalition membership
- Participation of members in committee work
- Competition for funding among member agencies

Results

- Created a toll-free number providing STD information and testing;
- Developed a website for providing STD information and testing;
- Provided a social marketing training for public health officials in collaboration with federal partners and capacity-building assistance providers;
- Developed a series of public information campaigns and public service announcements (print and radio) in a collaborative effort among numerous agencies serving African American communities in the Omaha metropolitan area;
- Increased STD screening in the Omaha metropolitan area;
- Increased funding for STD testing at the county and local level within the African American community through the Charles Drew Health Center and the Douglas County health Department;
- Identified pharmaceutical partners to provide drugs to treat STDs;
- Decreased meetings to bi-monthly and planned sustainable working goals and objectives; and
- After initial increase of STDs, the number has decreased dramatically in the Omaha metropolitan area.

Way Forward

The prescription recommended is to allow a community to come together to develop a coalition to address issues when public health officials cannot obtain an adequate response from the community. The success in this strategy is that a non-health entity stepped forward to take a key leadership role in developing an effective and efficient response to a community crisis. This coalition mobilized the community as well as community service providers to address the public health crisis.

New Jersey

Project Title: Rapid HIV Testing in New Jersey

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Description

New Jersey ranks fifth in cumulative reported AIDS cases, third in cumulative pediatric cases and has the highest proportion of cumulative AIDS cases in women. African Americans constitute the largest percentage of HIV/AIDS cases among the State's racial and ethnic groups. As a result, *Healthy New Jersey 2010* (HNJ2010) was developed with objectives focusing on knowledge of serostatus. A specific developmental objective of *Healthy People 2010* (HP2010) is to increase the number of persons who know their HIV status. A HNJ2010 mid-course objective is to increase the percentage of persons tested for HIV at publicly funded sites who receive their results. Rapid testing was initiated in New Jersey on November 1, 2003 following approval of the FDA approved and CLIA waived point-of-care rapid HIV test. The project was coordinated through the Office of the Medical Director in the Division of HIV/AIDS Services.

Objectives of Strategy

Based on an innovative model, a targeted approach was necessary to increase the proportion of at-risk persons testing for HIV and to increase the percentage of persons tested who received results. As of October 1, 2006, the strategy has been scaled up to include more than 160 sites that offered rapid HIV testing services.

Approach

Overall, the approach was to implement rapid HIV testing statewide in New Jersey's public health system. It was a project design incorporating rapid HIV testing at publicly funded counseling and testing sites to improve the proportion of high-risk persons testing for HIV and receiving their test result. The target populations (persons at risk for HIV disease) were reached via media campaigns targeting African American, Hispanic, and other high-risk persons which coincided with availability of rapid HIV testing in high prevalence areas of the state.

Challenges

Implementation of rapid HIV testing required a regulatory change that would permit point-of-care testing at HIV counseling and testing sites with an unlimited number of sites under a single laboratory director. A laboratory director needed to be identified. A quality assurance plan and associated laboratory log sheets, list of equipment, and testing monitoring protocol needed to be developed. The Centers for Disease Control and Prevention (CDC) HIV counseling and testing data collection tool needed to be revised to allow rapid testing specific data to be collected via local fields. A training program for both the counseling and testing components needed to be devised and given. Counselors needed to pass competency and proficiency testing and each site needed to obtain a laboratory license

prior to initiating rapid HIV testing at the site. Additional funding through state sources needed to be obtained to use in conjunction with CDC funding to expand rapid HIV testing to nontraditional sites such as emergency departments. Coordination with the state laboratory was needed to expedite confirmatory Western blot testing for persons with a preliminary positive rapid HIV test such that the results would be available no later than 48 hours after the specimen was received.

Results

- Increased knowledge of the patterns of testing and receipt of results from patients via the evaluation and monitoring system;
- Rapid HIV testing has precipitated integration of HIV testing into various venues such as emergency departments;
- Many patients have access to HIV testing through the emergency departments which, especially for many African Americans, may be their only source of health care (23 hospital emergency departments are funded for rapid HIV testing with 11,531 persons testing, 98 percent of persons receiving results, a 2.6 percent seropositivity, and 71 percent of those testing positive being newly diagnosed);
- The 20-minute time duration for testing and counseling assures patients will not leave the site before receiving their test results (99 percent of more than 88,000 persons tested received results compared with 65 percent of those receiving results when non-rapid HIV testing was done prior to 2003);
- The DHAS media campaign designed for the project was the first of its type for NJDHSS and was directly linked to the increased numbers of persons tested, especially African Americans, for HIV [1,139 persons visited programs during campaign];
- There was a reported 42.2 percent increase in the number of tests conducted.

Way Forward

- Locate HIV testing services at various sites with large numbers of African American clients such as HIV prevention programs, prenatal clinics, outpatient clinics, emergency departments, STD clinics, TB clinics, faith based initiatives, mobile vans, and federally qualified health centers;
- To ensure effectiveness and quality control, conduct program evaluation using data routinely gathered at the testing sites;
- Use standard CDC counseling and testing data collection forms;
- Develop and implement a media campaign targeting the African American community to increase awareness of the service;
- Identify and streamline laboratory facilities that handle and manage the analysis; and
- Program can be easily replicated with specialized training and coordination efforts.

Resources

Paul S, Cadoff, E, Martin E, Wolski M, Nichol L, Williams R, Bruccoleri P, Maung A, and Martin R. *Implementation of Rapid HIV Testing at Emergency Departments in New Jersey*. 2005 National HIV Prevention Conference, Atlanta, GA, June 12-15, 2005.

Paul S, Cadoff, E, Martin E, Wolski M, Nichol L, Williams R, Bruccoleri P, Maung A, Martin R., Berezny L, and Taylor C. *Rapid HIV Testing at Publicly Funded Counseling and Testing Sites: A Successful Statewide Initiative in New Jersey*. American Public Health Association 133rd Annual Meeting, Philadelphia, PA, December 12, 2005.

Paul SM, Cadoff EM, and Martin E. *Rapid Diagnostic Testing for HIV – Clinical Implications*. Clinical Virology and Infectious Disease. 2004 www.briefings.com/pdf/1043/Paul_edit.pdf

North Carolina

Project Title: Project Commit to Prevent

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Description

In keeping with the North Carolina Department of Health and Human Services mission to eliminate health disparities for racial and ethnic minorities, the Division of Public Health, HIV/STD Prevention and Care Branch developed Project Commit to Prevent (PC2P) on June 1, 2003. This project has as its overall goal to empower college/university students, with special emphasis on African Americans and American Indians, to change behaviors that put them at risk for HIV and STD infections. PC2P has increased community awareness about the issues that are associated with the spread of HIV/AIDS and STDs on college campuses as they impact students of color.

Objectives of Strategy

To achieve this end, the North Carolina HIV/STD Prevention and Care Branch partners with 11 of North Carolina's 12 Historically Minority-Serving Colleges/Universities to assist each institution with:

- Expanding HIV/STD prevention/risk reduction educational programs on campus;
- Enhancing the capacity of the health services on each campus to provide HIV/STD risk reduction services; and
- Strengthening linkages between each institution and other HIV/STD service providers near the campus, particularly those providing HIV/STD counseling and testing.

Approach

Peer Health Educators have been trained on each campus to promote HIV prevention through health education/risk reduction messages amongst their peers. One or two Campus Coordinators have been identified on each campus to oversee student activities. Campuses have co-sponsored health fairs, HIV/AIDS counseling and testing events, STD screenings, public service announcements, social marketing campaigns, and participated in student leadership workshops. Peer Health Educators partner with community-based organizations (CBOs) to conduct HIV 101 workshops to entering freshmen during orientation. Representatives from CBOs also train the Residential Assistants (RAs) on HIV/AIDS/STDs, who serve as a valuable resource by educating their hallmates on healthier sexual behaviors.

Examples of how Peer Health Educators increase awareness about how HIV/AIDS affects students of color in their specific age category include: dramatic plays/skits, creative public service announcements shown in the lunchroom, newsletters, door tags with counseling and testing information, book club discussions, participation in World AIDS Day (WAD) and National Black HIV/AIDS Awareness Day (NBHAAD) events, movie nights, campus forums, pizza parties, dorm outreach where they distribute safer sex kits, and by administering surveys.

Challenges

Funding is the primary barrier to overcome in order to sustain the life of this project. Currently, the project is supported by carryover funds from the CDC. Some campuses have experienced staff turnover, which affects the fidelity of the project. Campus administration has played a major role in limiting the types of HIV prevention messages that are spread among the students. Some campuses promote abstinence until marriage, and, therefore, do not allow condoms to be distributed. However, some students are still engaging in risky sexual behaviors. Not only would condoms help prevent the spread of diseases, but they could also help prevent unwanted pregnancies.

For fear that enrollment and funding will be jeopardized; some administrations do not allow HIV testing on site. They do not want to be labeled as “the school with an HIV problem.” This has proven to be a grave inconvenience for students who have to find transportation to CBOs or a local health department for services. As a result, some students may opt to not get tested at all and will not know their status. If a student were HIV-positive and did not have the option to get tested on their own campus with staff they were familiar with, they could potentially infect others with the disease unbeknownst to them.

Way Forward

The North Carolina HIV/STD Prevention and Care Branch recommends that the federal government appropriate funds to support the continuation of the project indefinitely. The HIV Prevention and Community Planning Unit has strongly encouraged all of the campuses to apply for funding once the competitive CDC RFA for fiscal year 2008-2010 is released on November 27, 2006. With this alternative plan, funding would be guaranteed for each project for three years as long as they remain in compliance.

Additionally, each campus administration would have to be addressed differently based on their religious beliefs and affiliations. Perhaps Campus Coordinators, Peer Health Educators, student organizations, CBOs, AIDS Service Organizations, local health departments, and others who share a vested interest in this public health concern could hold a public forum to discuss issues raised. Some students will continue to have sex, but they must also be provided with a safe and nurturing environment that will educate them on how to reduce their risk of infection, honor and respect their confidentiality, and provide them with preventative services.

Appendix 4

Suggested Job Descriptions for Minority AIDS Coordinator

Job Description A

Title: Minority HIV/AIDS Coordinator

Description: The Minority HIV/AIDS Coordinator is responsible for coordinating all HIV/AIDS initiatives that impact communities of color within health departments. The Minority HIV/AIDS Coordinator will help make all information and processes culturally relevant and ensure African American participation at all levels of policy development and program implementation.

Major Duties/Responsibilities:

- Coordinates and maintains a Minority Advisory Council (a diverse work group within the health department) and identifies key community stakeholders, including health professionals, educators, and faith leaders to serve on this advisory council.
- Leads the Minority Advisory Council in identifying community problems, prioritizing problems, and identifying community, state, and federal resources. Assists in the development and implementation of prevention services and strategies.
- Establishes collaborative relationships with minority-based or focused community organizations in the state as well as other health departments.
- Provides or coordinates technical assistance to community agencies, organizations, health departments, and other entities that provide HIV/AIDS services and/or prevention services to communities of color.
- Presents information at conferences, agencies, private industries, or public hearings.
- May oversee, create, and present grant proposals to private institutions or government agencies to secure grants and other forms of funding.
- Routinely assist with budget preparation and monthly reporting, etc.

Recommended Qualifications:

- Trained across the board in all issues
- Able to mobilize minority/African American communities
- At least five years experience working with African American communities
- An established rapport with communities
- Group process facilitation skills
- Experience in program development, management, administration, and fiscal management
- Working knowledge of non-profits with knowledge of HIV/AIDS and STDs
- Comfort with talking about sexuality, drug use, sexually-explicit risk behaviors, gay, and transgender issues
- Ability to deliver technical assistance
- Ability to identify external experts as required
- Ability to find and communicate funding opportunities
- Strong public presentation, oral, and written skills

Job Description B

Title: Health Program Administrator II

Description: The Health Program Administrator II will play a key role in organizing and coordinating an enhanced response within the AIDS Institute Division of HIV Prevention relative to meeting the needs of communities of color, with special emphasis on such highly-impacted populations as gay men of color/men who have sex with men of color.

Major Duties/Responsibilities:

- Collaborating and communicating with the three Bureaus within the Division, the Prevention Planning Unit, and other units within the AIDS Institute and the New York State Department of Health in the development and implementation of expanded efforts;
- Facilitating coordination with other organizations;
- Assisting in disseminating information about recent findings;
- Developing a comprehensive picture of existing activities conducted by AIDS-Institute-funded providers and other agencies; and
- Assisting in the creation of statewide strategies; and monitoring progress of multiple initiatives, and other related duties.

Minimum Qualifications:

- A Bachelors degree and four years of professional experience in the conduct of or administration of a public health, health regulatory, or human-services-related fields -OR-
- eight years of such experience. At least two years of experience must have included supervision of professional staff and/or program management. A Masters degree may substitute for one year of general experience.

Preferred Qualifications:

- Knowledge of HIV/AIDS prevention needs of communities of color, as well as issues associated with meeting those needs.
- Understanding of and experience dealing with substance users and gay men/men who have sex with men.
- Familiarity with issues, needs, and resources available for meeting the needs of young gay men of color in New York State is especially sought.
- Experience with operating and overseeing related publicly funded programs in a community-based setting.
- Good organization skills.
- Excellent verbal and written communication skills.
- Ability to work with a high level of independent responsibility.
- Experience in establishing and maintaining effective working relationships with individuals and agencies in the public and private sectors.
- Ability to travel throughout New York State and to national meetings.

Conditions of Employment:

Grant funded position

Application Procedure:

Resume must be received no later than MM/DD/YYYY at:
Health Research, Inc., A875P
One University Place
Rensselaer, NY 12144-3455

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The updated monograph was written by NASTAD staff and a working group of NASTAD's African American Advisory Committee. The NASTAD African American Advisory Committee is comprised of African American leaders in state health departments who provide their collective public health knowledge and experience to help inform NASTAD on various HIV/AIDS initiatives that target African American communities.

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The Tipping Point for HIV/AIDS Among African Americans

April 2007

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Why we can't wait:

NASTAD'S Mission and Vision

NASTAD strengthens state and territory-based leadership, expertise, and advocacy and brings them to bear in reducing the incidence of HIV infection and on providing care and support to all who live with HIV/AIDS. NASTAD's vision is a world free of HIV/AIDS.



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