

HIV Impact

A Closing the Gap newsletter of the Office of Minority Health, U.S. Department of Health and Human Services

HIV/AIDS Prevention Programs: What's Working with Our Youth?

By Linda Quander, Ph.D.

“Many HIV prevention and education programs for youth operate under a ‘one size fits all’ and ‘adults know best’ framework,” said Lynette Gueits, HIV/AIDS Acting Program Director at the National Council of La Raza. “But, HIV prevention programs targeting youth must fully incorporate youth culture and reflect realistic life situations,” she added. One of the best ways to do this is to involve youth in program development.

The Family and Youth Services Bureau (FYSB) within the Administration for Children and Families recommends that youth become active members of their communities. Many experts agree, youth who help out in their communities can develop new talents and abilities, learn valuable leadership skills, and are less prone to violence, substance abuse, or sexual activity that can put them at risk for HIV.

Youth Involvement

“Youth reaching youth is one of the best prevention methods,” said Yolanda Olszewski, Youth Program Coordinator at the Howard Brown Health Center in Chicago. Gueits points to a recent partnership between Charlas Entre Nosotros, the National Council of La Raza’s Latino Youth Peer-to-Peer HIV/STD Prevention Program, and the Latina American Youth Center. The collaboration resulted in a pilot youth-conceptualized/youth-driven multimedia presentation on HIV prevention that used salsa, reggae, and hip-hop music to convey the daily realities of HIV among urban Latino youth. The presentation was a three to four minute skit



with male and female teens, 16-19 years of age, discussing the transmission of HIV. Dialog for the skit was developed by the teens, and the skit used digital snapshots that were ultimately incorporated into a PowerPoint presentation for use by others in the field.

Metro TeenAIDS (MTA), during its 12 years of service to the Washington, D.C., Maryland and Virginia areas, has provided education and prevention resources to over 150,000 young people, family members, and youth workers.

MTA has a youth advisory board that takes part in their monthly planning. The program emphasizes youth versatility and variety, with popular activities such as game and movie nights as well as hip-hop parties. Sharon Twitty, a 17-year-old high school junior, said, “We are like one big family at MTA. We have fun activities that take us away from the negative things going on and have positive goals to empower us.” Twitty is a member of the New School Activists, a MTA group that creates positive messages to deliver to school and church groups.

Becoming a Responsible Teen (BART), headquartered in Santa Cruz, California, is one example of a national program that has been proven effective in reducing HIV risk behaviors. BART had significant input originally from a local advisory panel of teenagers in Jackson, Mississippi. These teenagers assisted program developers in naming the project, reviewing session content, suggesting situations and language for activities, and choosing the lesson leaders. BART’s developers felt that youth involvement was one of the critical factors that made the program successful.

The program targets African American males and females, ages

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STAFF

Blake Crawford
Executive Editor

Brigette Settles
Scott, MA
Senior Managing Editor

Linda Quander, PhD
Senior Editor/Writer

Paul Bouey
Jamie Bracey
Laura Oropeza
Jean Redmann
Guest Writers

John I. West
Production Coordinator

Stephanie Singleton
Graphic Designer

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14-18, who live in urban areas. Some objectives of the program are:

- To state accurate information about HIV and AIDS, including means of transmission, prevention and impact on the community;
- To clarify their own values about sexual decisions and pressures; and
- To demonstrate skills such as assertive communication, problem solving and risk reduction.

BART is part of CDC's Programs that Work (PTW) that was created in response to requests from schools for effective prevention programs. PTW identifies curricula with credible evidence of effectiveness in reducing health risk behaviors among youth, and provides information and training to educators from state and local education agencies, departments of health, and other national non-governmental organizations.

Connecting with the Community

Getting young people to assume an active role is only one element of effective prevention strategies. Just as important is garnering support from parents, faith-based programs, school administrators, and the community at-large. "Give me a school principal excited about HIV education and prevention, and I'll give you an entire school, faculty and student body more aware and better equipped to make decisions regarding sexual activity, drug use, and other important life issues," said Julie Hope, Director of Education and Outreach, AIDS Services Center, Anniston, Alabama.

CDC's researchers maintain that effective youth prevention and education programs are comprehensive—involving families, schools, peer groups, social systems, religious organizations, and any youth-serving agency. Further, programs must also be able to fit into the climate of a particular region or culture.

"For those of us in rural Alabama, with such a conservative climate, the HIV education programs of the American Red Cross and ACT SMART, a collaborative effort between the Red Cross and the Boys and Girls Clubs, have been most successful. The emphasis on sensitive, age appropriate materials with a non-judgmental approach has made us welcome in most venues—even churches and schools," said Hope.

Go Where Youth Go

Keleigh Matthews, Director of Programs at MTA, said "When we are out doing outreach in the community, we are not finding many youth at subway stations, playgrounds or even basketball courts. We are seeing most of them at urban clothing stores, independent record stores, barber shops, nail salons, hair braiding boutiques, mom & pop corner stores, and even McDonald's."

Most of these retailers allow MTA to leave literature in their stores—but are traditionally not prepared to answer any questions about HIV/AIDS. To confront this problem, MTA collaborated with urban retailers to train at least two staff members in the areas of HIV/AIDS, youth development, and mentoring. "We think everyone will benefit from this collaboration. First, the youth will see that there are people out there—other than their parents, schools and social programs—who are concerned about their well being. No matter where they go, they will get a clear message about HIV and hopefully feel that they have another outlet to be heard," Matthews added.

One Size Does NOT Fit All

When dealing with gay, lesbian, bisexual, and transgender youth—especially those of color — prevention programs must be tailored to this audience. Advocates for Youth, an organization that helps young people make informed and responsible decisions about reproductive and sexual health, notes that many HIV/STD prevention programs targeting gay youth seldom meet their needs. Some gay youth do not relate to gay-specific messages because they do not self-identify as "gay." Others fear the social stigma and violence—sometimes intensified by culture and religion—directed at those identified as homosexual, while others self-identify as bisexual, and do not internalize gay-specific messages. Some examples of programs successfully reaching its target include:

- **Youth Guardian Services** in Manassas, Virginia, is a youth-run, non-profit organization that provides support services through peer-operated, Internet-based projects and programs targeting gay, lesbian, bisexual, transgender, questioning, straight supportive, and HIV-positive youth. This organization also works with other non-profit groups to

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Native Americans Strategize to Integrate HIV Prevention and Substance Abuse

By Laura Oropeza, Program Manager • Paul Bouey, PhD, MPH, Acting Executive Director
National Native American AIDS Prevention Center

The National Native American AIDS Prevention Center (NNAAPC) recently held “Gathering Our Wisdom,” the First Annual Native American Substance Abuse/HIV Prevention Conference in San Diego, California, from January 21-23, 2001. Over 100 people from across Native America came together to network, strategize, and prioritize for Native-specific HIV and substance abuse prevention program development, policy, community mobilization, and research.

Substance abuse has been a long-standing problem in many Native American communities. The U.S. Congress passed the Indian Alcohol and Substance Abuse Prevention and Treatment Act (1986), 25 U.S.C. Section 2411, based on findings that “alcohol and substance abuse are the most severe health and social problems facing Indian tribes and people today, and nothing is more costly to Indian people than the consequences of alcohol and substance abuse...” HIV infection is potentially one of these consequences. Individuals place themselves at higher risk for HIV infection when using alcohol and other substances. Despite the fact that racial misclassification and inadequate reporting from some states tend to underestimate the actual numbers, HIV infection rates for American Indians/Alaska Natives, as reported by the Centers for Disease Control and Prevention (CDC), have continued to increase annually.

This conference was the first of its kind and successful in accomplishing its goals. NNAAPC, along with community members, organized this conference to provide a forum for Native American substance abuse treatment programs; to mobilize coordination of integrated HIV prevention and substance abuse treatment efforts; and to define national policy agendas for substance abuse and HIV prevention in Native American communities.

Susan Masten, President of the National Congress of American Indians (NCAI), emphasized that, “our people are dying from preventable diseases due to poor surveillance and silence.” Masten also stated that we have the responsibility to bring HIV to the attention of tribal leaders. Tribal leaders need to be responsible to the people as the elected officials of the people. Masten encouraged people to utilize NCAI to develop a formal plan involving tribes, the Indian Health Service, and other national programs.

Underlying all efforts is recognizing the nature of the epidemic in local and national venues, and placing an emphasis on those areas in greatest need. Community involvement is a critical requirement in this entire venture. Commu-

nity members must become activists, place HIV/AIDS and substance abuse on the community agenda, and obtain leadership and tribal council buy-in to confront this dual epidemic in all of its manifestations. Discussions also focused on the imperative to increase awareness of resources and how to obtain them. Training is available through NNAAPC and through regional AIDS Education and Training Centers to improve these processes and must be fully utilized.

Open dialogue with other communities, national organizations, Federal and state agencies is also vital. These lines of communication allow for greater understanding on all sides, and for more effective leverage to influence action on specific issues. This network of relationships can be used to best advantage when partnerships are formed (e.g., between tribes and NCAI) and strengths combined.

Since 1988, NNAAPC has worked diligently to bring Native American HIV/AIDS issues to national attention. The stigma associated with HIV/AIDS in most Native American communities, and inherent homophobia, have made this effort a challenge. Through networking and collaborating with other Native American organizations, NNAAPC has gained the trust and respect of many Native American communities. This is not an easy task considering there are more than 500 federally recognized tribes, each with its own tribal government, beliefs, values, and way of life. What works for one community may not work for another.

NNAAPC is presently working with the U.S. Surgeon General, Dr. David Satcher, on a national campaign to destigmatize HIV/AIDS in Native American communities. As part of this campaign, Dr. Satcher addressed hundreds of tribal leaders by satellite broadcast at the 2000 NCAI Leadership Summit, followed by a compelling press conference by Dr. Eric Goosby, Director of the Office of HIV/AIDS Policy, U.S. Department of Health and Human Services. By creating this awareness with tribal leaders, and supporting community members to hold their tribal leaders accountable, NNAAPC is hopeful that the HIV prevention message will reach deep into heart of Indian Country.

NNAAPC operates various CDC prevention programs; manages a national case management network through a grant from the Health Resources and Services Administration, Special Projects of National Significance; and provides evaluation and technical assistance services through other grants. For more information, contact NNAAPC at 510-444-2051, or visit our website at <http://www.nnaapc.org>.

provide them with Internet services. For more information, call 877-270-5152, or go to <http://www.youth-guard.org>.

- **CDC's Community Intervention Trial for Youth** is specifically targeted toward young men of color. This prevention research project is currently developing and evaluating a comprehensive, community-level program to motivate young men who have sex with men to reduce HIV risk behaviors. For more information, call Esther Sumartojo, Ph.D. at 404-639-1938, or send an e-mail message to esumartojo@cdc.gov.
- **The American Psychological Association's Healthy Lesbian, Gay and Bisexual Students Project** aims to increase the effectiveness of school counselors, health care and mental health professionals in educating students about health risks and promoting healthy lifestyles. This project is funded through a cooperative agreement with CDC's Division of Adolescent and School Health. Training activities are offered at national and regional conferences as well as pilot sites for in-depth training interventions that includes school board members, school health professionals, principals, and teachers. For more information, call 202-336-5977, or go to <http://www.apa.org/ed/hlgb>.

During the last decade, minority youth were particularly hard hit by HIV/AIDS. *Youth and HIV/AIDS 2000* by the Office of National AIDS Policy noted that young women and young men who have sex with men—especially those of color—are at greater risk for HIV than other American youth. Experts agree that these findings of increased risk underscore the need to reach minority youth by getting them involved in community programs and reaching out to them in innovative ways. &

HIV/AIDS and Minority Youth: Facts and Statistics

- African American and Latino teens, ages 13-19, each represent approximately 15 percent of all U.S. teens. Yet, African American teens account for 60 percent of new AIDS cases, and Latino teens account for 24 percent of new cases.
 - Although young African American women, ages 13-19, represent 15 percent of all U.S. young women, they account for 66 percent of all AIDS cases reported among young women.
 - In a sample of young men who have sex with men, ages 15-22 in six urban counties, researchers report that a higher percentage of African Americans (13 percent) and Hispanics (5 percent) are infected than whites (4 percent).
- Source: Centers for Disease Control and Prevention, HIV/AIDS Surveillance Reports 1999-2000. For more information, call 800-311-3435, or go to <http://www.cdc.gov/hiv/dhap.htm>.*
- Compared to white teens, African American teens are more than twice as likely and Latino teens are one and a half times as likely to say that they are very concerned about becoming infected.
 - More than one in four African American teens and one in five Latino teens say they know someone who has AIDS, has died from AIDS or has tested positive for HIV.

Source: Kaiser Family Foundation, National Survey of Teens on HIV/AIDS 2000. For more information, call 800-656-4533, or go to <http://www.kff.org>&

International AIDS Candlelight Memorial

On May 20th, 2001, thousands of individuals in over 300 communities in 60 countries simultaneously participated in the world's largest and oldest annual grassroots HIV/AIDS event.

The International AIDS Candlelight Memorial is designed to honor the memory of those lost to HIV/AIDS, show support for those living with HIV/AIDS, raise awareness of HIV/AIDS, and mobilize community involvement in the fight against HIV/AIDS. This year's theme was One Voice, Many Faces...United for Life.

For more information, contact the Global Health Council at 202-833-5900, or e-mail candlelight@globalhealth.org&

National HIV Testing Day

Each year on June 27th, the National Association of People With AIDS (NAPWA) leads a nationwide effort to encourage people to know their HIV status.

This effort has come to be known as the National HIV Testing Day (NHTD) Campaign. The campaign began five years ago as part of NAPWA's ongoing efforts to improve the health of people living with HIV through participation in voluntary HIV antibody testing and counseling programs.

NAPWA works with testing centers, community health providers, and local and state health departments nationwide to promote increased voluntary utilization of testing and counseling services.

The campaign is sponsored, in part, by the Centers for Disease Control and Prevention, the Health Resources and Services Administration, and the National Alliance of State and Territorial AIDS Directors.

For more information, go to NHTD's web site at <http://www.napwa.org/nhtd.htm>, or e-mail cperkins@napwa.org&

New Orleans (NO) AIDS Task Force C.A.N. Internet Intervention

By Jean Redmann

This article highlights recent technical assistance provided by OMHRC.

The office is a small building tucked away on a busy street just outside the French Quarter in New Orleans. A small sign labels it Community Awareness Network or C.A.N. Step inside and the bowls of condoms and safer sex posters make it clear that the focus here is HIV prevention. Two of the workers are hunched over their computers in the position often assumed at grant or quarterly report time. But these men aren't doing paperwork, they're doing prevention.

"The Internet has now become the 'parks and bushes'—the place people meet to have anonymous sex," notes Felicia Wong, coordinator of the project. Less than a year ago, NO/AIDS Task Force received funding from the Centers for Disease Control (CDC) to begin a program of community mobilization targeting Men Who Have Sex With Men (MSM) in the French Quarter and surrounding area, which has both a high gay population and high rates of HIV/AIDS. In August 2000, the building was empty, but now it's filled with prevention resources, people, and several computers. "From the beginning, we knew we wanted to do something online," Wong said, "but we weren't quite sure what. Our goal is to target community norms, and more and more the Internet is a way that people communicate and create those norms."

When searching for other programs to emulate, the only one that the staff was able to locate was a fledgling program in San Francisco. While there may be other AIDS organizations wanting to start up programs, this area of prevention work is so new that few models exist. "We used one idea from San Francisco," said Mark Monk, one of the program's staff. "I go online as *Stop HIV NO* and hang out in the men seeking men chat rooms. A lot of men ask me about risk behaviors, or about testing." But the NO/AIDS C.A.N. project goes further. The anonymous aspect of the Internet allows people to both hide and be honest—their name isn't known, so they can say what they really think. Mark and fellow program staff Roberto Rincon and Thomas Franklin also visit chat rooms without the label of HIV prevention (and it's implication of 'safer sex police') attached. They chat with the men in the New Orleans rooms about safer sex and why it's important. "I don't get stuck behind the tag 'HIV prevention worker,'" says Thomas Franklin, "I'm also a member of this community and I can talk to people just as another person."

"We don't want to hide or mislead," Wong notes, "but we do

want to work at a level that leads to real change in community norms and values. Our agenda is not to enforce any risk reduction, but to make sure that people get the right information and have a chance to think and talk about the choices that they make."

One of the biggest challenges has been to develop a protocol for the work. The Office of Minority Health Resource Center (OMHRC) has been working closely with the program, offering a workshop on community mobilization to all the MSM prevention providers, and also working with the NO/AIDS Task Force staff to create specific procedures for conducting the Internet interventions as well as offering one-on-one Technical Assistance. "We really had to start at ground zero and create our own system," Wong said, "and OMHRC has been great in helping us find our way through this." NO/AIDS C.A.N. now



has a solid draft of best practices, guidelines for staff and volunteers, and a "how to" guide of Internet HIV interventions. Some issues are obvious—such as confidentiality and staff/client boundaries—but other issues were thornier. "I stumbled onto someone who became obsessed with me," Roberto Rincon said, "What do you do in a situation like that?" The answer the staff came up with was to document the incidents, notify a supervisor, and discontinue using that online name. Staff safety and professional relationships are very important and integral to the success of the program.

Evaluations are another challenge. In the first year of the grant, NO/AIDS C.A.N. measured the number of chats, but this year they changed to minutes per chat. "A chat can last from three minutes to half an hour. Using time is a more consistent measure," explains Wong. "We're also monitoring community norms, rates of HIV infection, and other markers, although it might be hard to directly trace any change solely to the chat rooms. We're still exploring ways to more effectively evaluate our Internet preventions. My advice for anyone starting up is to both learn from what others are doing—we're more than glad to share our experiences—and be creative enough to adapt to your community's needs."

"It is a challenge at times, especially if you're not a chat room type," notes Franklin, "but we've got a good team. I'm African-American, Roberto's Latino and Mark is Caucasian, so

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Connecting the Dots: Cultural Competency in Communities of Color

Guest Editorial by Jamie Bracey

The first time I heard the term “cultural competency” was fifteen years ago when the National Association of Black Social Workers issued its provocative stance against transracial adoption. A battle ensued over whether White Americans had the capacity to adopt and raise Black children in a culture based on White racial superiority. For me, the more important question was whether the social infrastructure of the Black community was growing too weak to absorb and help shape the future of its own children. And if this trend was affecting America’s largest minority group, how would it play out in terms of self-determination for other sub-groups, if at all?

Thus cultural competency was born, not as a celebration of the richness of each culture’s contribution to the world’s development, but out of an emotionally charged argument over whether White institutions were better qualified to manage another minority issue. In this case, affecting the adoption of Black children, against the cultural protests of leading Black family advocates.

Cultural Competency in the 21st Century

Fast forward to 2001, and the cultural competency stakes are even higher. In relationship to HIV/AIDS, the current demand for cultural competency plays out as a need to train a predominantly White medical community to handle life-threatening diseases that disproportionately affect minorities.

But again, the issue is much deeper than that. Culture dictates social behavior, what is acceptable and what is not. How we make decisions, what the implications are, and what kind of psychic defense we need to adjust in a society that is still largely playing out preferences based on race.

In theory, sub-groups (minorities) that assimilate into a majority culture can survive and excel by bringing their cultural attributes to the table. In reality, “minority” groups are likely to experience what I call the “dilution” factor, or a break down in the core social constructs that make their culture unique.

Is that a bad thing? Not in our dream of Dr. King’s “beloved community,” where all people of all colors achieve and thrive together. But we’re not there yet. The challenge for communities of color is to recognize that there is a critical need to identify and hold on to their shared group experiences, and avoid dilution until our country can come to consensus that we are stronger together than separated, and that there is value in every human being.

It is culture, the learned responses to handle what is going on around us, that sub-groups need to have to survive in a majority culture that can be hostile as it struggles with its own internal problems.

The challenge for leaders of community-based organizations (CBOs) serving communities of color is to identify and develop consensus on what their current culture is, and what external factors influenced the behaviors of their sub-group a generation ago, and that will influence behavior and choices two generations ahead.

This is such a tremendously important point to understand, and requires almost superhuman will power to achieve. But let’s look at the impact of not connecting to culture.

Impact of Cultural Disconnection

The case can be made that for hundreds of years, African Americans were forced to assimilate into the majority American society. Not able to connect to a specific country (the entire continent of Africa is a little vague), and lacking any other language or social infrastructure, America’s largest minority group has seen its social infrastructure fluctuate based on the whims of the majority culture it has emulated. Co-existence based on a hybrid, forced, cultural foundation.

This legacy is much different, but no less real, than what immigrant groups experience within one or two generations of coming to America. The difference is that those groups have maintained the option (the choice) to connect to a geographic location (ethnicity), or country (nationality), and have a stronger likelihood of healing themselves by rejuvenating themselves through their culture.

In either case, leaders of minority-led CBOs who can’t articulate the primary codes of behaviors impacting their communities, and lack an inventory of skills and models to influence change, cannot be surprised when the majority society asks: “*Why should you have access to limited resources if your programs or operations don’t seem to help your people any better than the results we’re achieving from non-minority agencies serving the same groups?*”

Last year our firm, True Image Communications, LLC, developed an instrument to help community leaders assess their own comfort with cultural competence. Executive Directors and program staff completed “The 3 Habits of Culturally Competent People™”, and were often surprised at how much work it actually took to become culturally competent.

Another point we make abundantly clear is that being a person of color does not automatically mean you are culturally competent. Hopefully the preceding paragraphs make that distinction clear.

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Developing Culturally Competent Organizations

Cultural competence is challenging because it is a deeper concept than previous attempts to co-exist in America. More powerful than affirmative action (giving access), diversity (employee management), and even multicultural training (respect of different social groups), it takes courage, vision, and a different level of professional accountability.

First, let's understand that cultural competence is the core ingredient of a high-performing organization—one that is operationally sound, fiscally accountable, and participates as a respected stakeholder in its city, town, or region. Second, competitive, high-performing organizations incorporate cultural competency at the mission, policy, and programmatic level.

Every decision of the Board is based on maintaining a healthy balance between the laws and mores of the majority culture, while also taking into consideration the best strategies to produce the best decisions for the community they serve.

For African American community organizations, and those groups most disconnected from their original culture, it is time to stop complaining and raise the bar. If emulating majority society has not stopped disproportionate levels of disease, incarceration, family breakdown, and every other pathology we can name, then there is no excuse not to make a change.

Minority leaders must do their homework to identify those cultural attributes that will most likely heal ourselves, while allowing us to engage the majority community more effectively. People respect people who know who they are. Not connecting to an original culture, either willfully, or subconsciously, can be construed as a lack of self respect that other groups can take advantage of. Clearly, the power of developing a code of behavior depends on focusing on family development. Family transmits culture, and high-performing families transmit not just codes of behaviors, but hopes and dreams for the future.

Every decision regarding resource allocation and program development should be viewed through the cultural lens developed by the organization. What attributes will this problem require, what attributes do we currently have, what resources can we call on that are unique and most likely to engage potential consumers to improve their quality of life?

Leading Culturally Competent Organizations

Leaders of “minority-led” human service agencies have another, equally complex responsibility. They have to structure their organizations to meet Euro-centric standards of performance, while also validating that they actually have something unique to offer the minority communities they serve. It's not easy, but there are some general rules of thumb for CBOs serving predominantly minority communities:

- Keep your culture in your programs, but report your results in the manner required by the institution that gave you funding.
- Never hide behind culture to excuse poor performance, it disrespects who and what your organization represents.
- An alliance beats a zero, and collaborating with other organizations may give you a chance to incorporate professional development that your organization may need to improve its overall performance.
- Organizations that consistently deliver results are given more flexibility than others, so work to exceed expectations.
- Earn the right to take a key leadership position in your region by communicating a consistent message of achievement.

In high-performing organizations, cultural competence is reflected in professional staff that spends time with strong, healthy people of different cultures, rather than gathering knowledge from media, or stereotypes derived from working with the troubled clients of that culture.

The introductory, intermediate and advanced skill sets required to achieve cultural competency are incorporated into the professional development plans and work plan goals and objectives of each agency contract.

Those skill sets can range from familiarity with the current and key historical heroes and sheroes of that culture, to advanced training and sustained social, economic, and political interaction with identified leaders of another cultural group.

Within the organization, a culture of high performance will also include giving employees credit for becoming subject matter experts on the cultural assets of groups the agency seeks to serve, and that credit is reflected in on-going recognition opportunities.

Ultimately, high-performing organizations role model cultural alliances, and are both humble and confident when approaching other cultures to help meet their needs. It is a lifelong commitment to helping build an America that has the capacity to heal the tremendous economic, spiritual and health disparities that threaten our collective well-being.

Jamie Bracey is a Principal of True Image Communications, specializing in strategic planning and leadership development for state and national clients. A certified corporate trainer and motivational speaker, Ms. Bracey is also an organization development consultant to the National Minority AIDS Council (NMAC), and is a member of the national advisory board to the African American Prevention Intervention Network, and the OMHRC Resource Persons Network. 

Reducing HIV/AIDS Risk Among Migrant Farmworkers

Linda Quander, Ph.D.

According to Bobbi Ryder, Chief Executive Officer of the National Center for Farmworker Health, “Farmworkers with HIV/AIDS are not coming to the clinics on their own for regular health care. We *must* reach out to them.” In *HIV/AIDS: A Growing Crisis Among Migrant and Seasonal Farmworker Families*, the National Commission to Prevent Infant Mortality found that migrant and seasonal farmworkers are at higher risk for HIV/AIDS than most Americans. Carlos Soles, an HIV/AIDS Training Specialist at the Office of Minority Health Resource Center said, “Unfortunately, the truth of the matter is that very few organizations spend their time or money dealing with the farmworker population.”

The migrant community, like other minority communities, bears a disproportionate burden of disease. The U.S. Department of Labor estimates that approximately 80 percent of migrant and seasonal workers are Hispanic.

Experts find that linguistic, educational, financial, cultural, and geographic barriers pose great challenges to migrant workers who seek health care services for themselves and their families. According to Myrtelina Gonzalez, Director of Training at the Farmworker Justice Fund in Washington, D.C., “The majority of farmworkers do not speak English and are not educated above the eighth grade level. Also, many farmworkers are unable to obtain regular health care for themselves or their families due to high rates of poverty and a lack of private medical insurance or other benefits, including Medicaid.”

In responding to migrant farmworkers’ lack of knowledge of available services as well as lack of accessible or adequate medical care in underserved areas, the National Center for Farmworker Health in Buda, Texas, assists farmworkers in identifying the closest migrant or community health center through its Call for Health program. In addition, the Friends of Farmworker Families Fund supports Call for Health with financial assistance to farmworkers and their families. Other factors that increase the risk and act as barriers to HIV/AIDS prevention and care are the cultural taboos restricting discussion of sexual issues, especially by women. Gonzalez added, “Only a few of those who attended our first training had ever spoken freely about sexual behaviors or condom use—especially in public.”



Survival Strategies for Migrant Farmworkers

The National Coalition of Advocates for Students in Boston, Massachusetts, offers training for the effective use of the *Nosotras Viviremos* (We Will Live) curriculum in states with high migrant populations. *Nosotras Viviremos* is a bilingual (English/Spanish) curriculum which is culturally competent, age-appropriate, and gender sensitive. Prevention information and training targets young Latina female farmworkers and their mothers and/or mentors.

The curriculum was developed by collaborating with four Florida-based organizations for farmworkers, adult female farmworkers and female youth from farmworkers’ families. Among participatory techniques used to design the curriculum was an assessment of community needs through focus groups. Issues discussed in focus groups included knowledge about sexual development, beliefs and stereotypes about HIV/AIDS, cultural values and practices, communication, and prevention education.

Through *Promotores de Salud* (Farmworker Leaders for Health), the Farmworker Justice Fund collaborates with the National Council of La Raza and local community-based organizations in large migrant and seasonal farmworker areas to provide HIV/AIDS prevention education using peer counselors. Support and supervision comes from the CDC. In 2000, the Farmworker Justice Fund received one of CDC’s National Business and Labor Awards for Leadership on HIV/AIDS.

According to Gonzalez, “From January 1, 1999, to July 30, 2000, over 20,000 farmworkers and/or family members were educated, thousands of condoms were distributed, and hundreds of referrals were made for HIV testing and other medical services.” *Promotores* have created HIV prevention plays as well as made presentations at a number of local, state, and national conferences. They have also written, produced, and published an HIV prevention “fotonovela” that provides health education through a comic book style publication.

Monthly meetings of the *promotores* are held in partnership with local community-based organizations. At the conclusion of each project period, the *promotores* attend an evaluation session. This activity helps to define the project’s successes as well as needs and plans for future improvement.

For more information about reducing HIV/AIDS risk among migrant farmworkers, see Resources on page 14, or call the OMHRC at 1-800-444-6472.

Visit the *NEW* OMHRC Minority HIV/AIDS Initiative Web Site



The new OMHRC web site—<http://www.hiv.omhrc.gov>—makes available, up-to-date information on a variety of topics to assist OMH with its goal to reduce the impact of HIV/AIDS on racial and ethnic minorities. You can click on the latest information about upcoming conferences, meetings and technical assistance workshops, review current research news, funding, and employment opportunities, as well as catch up on the Initiative's ongoing activities. *HIV Impact* is also available and can be downloaded from our web site.

Do you have comments or suggestions about the site? Send them to hivinfo@omhrc.gov.

H I V / A I D S T R I V I A

Q On what day did the CDC report the first AIDS case in the United States?

A June 5, 1981. This year marks the 20th anniversary.

Improving Cultural Competence within Your Organization

By Linda Quander, Ph.D.

In the Winter 2001 issue, Part 1 of this article included answers to your questions about how health care professionals can become more culturally competent. Part 2 of this article includes recommendations from experts concerning improving cultural competence within your organization. The challenge to your organization is to create an environment where cultural competence is viewed as an opportunity for growth, rather than as a problem.

Published by the Academy for Educational Development and the National Youth Leadership Council Service-Learning Diversity Project in 2000, *Creating Inclusive Communities: An Inquiry into Organizational Approaches for Pursuing Diversity* states, "A diversity initiative is more likely to succeed when change is necessary to fulfill the organization's mission rather than when motivated by legal obligation...or a sense that the majority must respond to the minority's needs."

Experts suggest that your organization involve the community you serve in activities beyond health education and outreach. For example, Suganya Sockalingam, Ph.D., Assistant Project Director at the National Center for Cultural Competence at the Georgetown University Medical Center, said: "Community members should be involved at all levels—from program planning and development to implementation. They should also participate in the assessment of community strengths and health needs, policy and budget development, program monitoring and evaluation, function as governing board and advisory committee members, and serve as paid consultants to the program."

Experts also encourage organizations to ask for feedback from its clients. For example, Joan Ferguson, Community Coordinator for Blacks Assisting Blacks Against AIDS in St. Louis, Missouri, said, "Ask for your clients' help, suggestions, advice, and opinions about how to make

the services they need work for them. You should get constant feedback through surveys, focus groups, questionnaires, and suggestion boxes, so that their needs (not what you think they need) are being met."

In addition, experts recommend that your organization extend its outreach through peer education. Ferguson added, "make information accessible to clients in your community. They shouldn't have to come to where you are to get the information that they need, but make them a part of the dissemination process."

Finally, in a 1999 edition of the Joint Commission on Accreditation of Healthcare Organization's *Benchmark*, experts suggested several actions to improve your organization's cultural competence:

- Ensure administrative and policy support because it is difficult to be a culturally competent practitioner in a system that does not support cultural competence with policy.
- Conduct a cultural audit in order to assess the staff's knowledge of your patients' needs, expectations, cultural beliefs and practices.
- Look at the composition of your staff in order to build a diverse workforce.
- Make diversity an important part of your quality improvement efforts.
- Secure financial support for training and education.
- Forge relationships with communities and culturally competent vendors.
- Ensure high-quality interpreter and translation services.

For more information about cultural competence, see *Resources* on page 15, or call the OMHRC at 1-800-444-6472. 

Multicultural Competency Assessment for Organizations

The *Multicultural Competency Self-Assessment for Prevention Service Providers* tool was provided in the Winter 2001 issue. As a follow-up, the *Multicultural Competency Assessment for Organizations* appears below. Each instrument was developed by the Wisconsin HIV Prevention Community Planning Council, in consultation with Nara Smith Cox, Ph.D., Associate Professor, University of Wisconsin at Madison, Department

of Professional Development and Applied Studies.

This tool was designed to assess perceptions of your staff and clients about how well your organization provides multiculturally competent HIV prevention services for people with different backgrounds. It serves as a group discussion guide to identify and discuss areas in which your organization is multiculturally competent and also areas in which improvements can be made.

For more information about the assessment tools, contact Dr. Cox at 608-262-2730 (nc6@mail.dcs.wisc.edu) or Molly Herrmann, Wisconsin HIV/AIDS Program, Community Planning Coordinator at 608-267-6730 (herrmmm@dhfs.state.wi.us).

Rate this organization's current level of multicultural competency on a scale from 1 (not at all) to 5 (extremely).

At an AGENCY level, this organization...

1. Has a written mission or vision statement supporting multiculturalism throughout the organization.

1 2 3 4 5

2. Has a Board that includes a significant number of members reflective of the population the agency serves and intends to serve.

1 2 3 4 5

3. Has policies to assure that decision-making processes include the voices of less powerful staff members and also minority opinions.

1 2 3 4 5

4. Has an institutionalized commitment to recruitment and retention of staff reflective of the populations the agency intends to serve.

1 2 3 4 5

5. Has a systematic and long-term commitment to educate board members, employees, and volunteers about multiculturalism.

1 2 3 4 5

6. Shows its commitment to the communities served by involving community members in the design and evaluation of services and programs.

1 2 3 4 5

At an ADMINISTRATIVE level, this organization...

7. Has advisory boards, task forces or committees that include a significant number of culturally diverse community members.

1 2 3 4 5

8. Implements policies requiring the following individuals to participate in multicultural training:

Board members	1	2	3	4	5
Staff	1	2	3	4	5
Volunteers	1	2	3	4	5

9. Has a staff reflecting multicultural diversity at all levels of the organization.

1 2 3 4 5

10. Uses position descriptions that identify expectations related to knowledge, sensitivity and skills to serve diverse populations.

1 2 3 4 5

11. Advertises position vacancies in diverse print, other media and organizations reaching diverse populations.

1 2 3 4 5

12. Has personnel policies that respect cultural differences (e.g., leave time is flexible to accommodate differences in holidays or important community or family events).

1 2 3 4 5

13. Provides opportunities for Board members, staff and volunteers to engage in self- and agency assessment.

1 2 3 4 5

At a SERVICE DELIVERY or DEPARTMENTAL level, this organization. . .

14. Uses an intentional process (e.g., needs and strength assessment) to collect information about the local target population from a variety of sources.

1 2 3 4 5

15. Collects information to assess diversity among clients and staff.

1 2 3 4 5

16. Can adequately respond to needs of clients whose primary language is different from that of the majority population served by the organization (e.g., Spanish, Hmong, American Sign Language, etc.)

1 2 3 4 5

17. Actively involves individuals reflecting relevant differences (as listed below) in planning and design of prevention programs. On-going feedback from diverse individuals is obtained throughout the implementation and evaluation stages.

Ethnicity	1	2	3	4	5
Gender	1	2	3	4	5
Sexual orientation	1	2	3	4	5
Age	1	2	3	4	5
HIV status	1	2	3	4	5
Other:	1	2	3	4	5

18. Has developed service linkages and working relationships with other agencies serving the same client population.

1 2 3 4 5

19. Assures that clients are provided information in their primary language (through video, publication, with services of a translator, or appropriate referral).

1 2 3 4 5

20. Provides client-centered services, which means the client's confidentiality is strictly maintained and the client retains the right to accept and reject services and to include partners, family members and others in these services.

1 2 3 4 5

AND/OR

21. Provides population- or group-centered prevention education to address the needs and strengths of program participants.

1 2 3 4 5

22. Makes referrals to other agencies, as appropriate, and prepares clients for interactions at these agencies.

1 2 3 4 5

23. Involves clients and members of the community served in evaluation of the prevention programs.

1 2 3 4 5

24. Documents and acts upon grievances and affirmations, with particular attention to issues related to cultural differences.

1 2 3 4 5

25. Evaluates the outcomes of programs to determine whether the target populations are being served and whether the programs are successful in changing behaviors and norms consistent with the WI HIV Prevention Plan and State priorities.

1 2 3 4 5

CONCLUSIONS

1. What are the most significant ways in which this agency (or department) strives for multicultural competency?

2. What are the three most important indicators this agency (or department) should focus on to enhance its multicultural competency? For each of these 3, what are the next steps that need to be taken?

- **Cultural Competency Guide:** The Health Resources and Services Administration (HRSA) has released a new guide, *Quality Health Services for Hispanics: The Cultural Competency Component*, to help health professionals better understand and respond more effectively to the special needs of Hispanics in the U.S. This guide emphasizes the central role of cultural competence in providing quality primary and preventive health care to Hispanics. The guide is a result of a collaboration between HRSA's Bureau of Primary Health Care, the Substance Abuse and Mental Health Services Administration, the Office of Minority Health and the National Alliance for Hispanic Health. *For more information, call 888-AskHRSA, or go to <http://www.ask.hrsa.gov>.* &

- **New Addition to MEDLINEplus:** The National Library of Medicine has added a daily health news feed from the major U.S. print media to MEDLINEplus, its consumer-friendly site. Each weekday morning the home page of <http://medlineplus.gov> will be updated with health-related articles selected from the Associated Press, New York Times Syndicate, and the United Press International. Special arrangements have been made with these publishers to make the articles available, and more sources will be added in the future. *For more information, go to <http://www.nlm.nih.gov>.* &

- **Nine More States Receive HHS Grants to Develop Plans Extending Health Insurance Coverage to all Citizens:** In February 2001, Health and Human Services (HHS) Secretary Tommy G. Thompson announced that nine states have received one-year State Planning Grants totaling \$10.2 million to develop plans for providing their uninsured citizens with affordable health insurance. The newly funded states, Arizona, California, Colorado, Connecticut, Idaho, South Dakota, Texas, Utah, and Washington, join 11 others that received grants last year. Administered by HHS' Health Resources and Services Administration, grantees will conduct studies to identify characteristics of their uninsured citizens. Next, the grantees will determine the most effective methods to provide all state citizens with high-quality, affordable health insurance similar to plans that cover government employees or other benchmark plans. *More information about the program is available at <http://www.hrsa.gov/stateplanning>.* &

New Orleans...continued from page 5

we cover most of the bases." Wong adds, "Computers and the Internet aren't going away, they're only going to become more and more a part of our lives. We have to make sure that HIV prevention keeps up with the technology."

Jean Redmann is an author and Director of Education at NO/AIDS Task Force in New Orleans, Louisiana. For more information, call 504-945-4000, or e-mail cmproj@bellsouth.net. &

New Survey of AIDS Drug Assistance Programs (ADAPs)

According to the most recent survey of ADAPs, increases in the number of clients, rising drug costs, and more complex treatment regimens have caused many states to place limitations on their ADAP programs. Program limitations include lower financial eligibility criteria, smaller formularies, enrollment caps, and restricted access to antiretroviral medications. Yet, even with these restraints, these federally funded, state-administered programs are expanding their role in providing HIV-related drugs to underinsured and uninsured individuals living with HIV/AIDS.

This annual survey was conducted by the National Alliance of State and Territorial AIDS Directors and the AIDS Treatment Data Network for the Kaiser Family Foundation. This survey gives an overview of the status of ADAPs, and documents how these programs are responding to fiscal, clinical, and epidemiological changes in the current HIV/AIDS epidemic.

The National ADAP Monitoring Project: Annual Report, March 2001, along with a fact sheet on ADAPs, can be found at <http://www.kff.org/hiv>. For more information about the report, contact Jennifer Kates, a senior program officer at the Kaiser Family Foundation, at 650-854-9400.

Updated HIV Treatment Guidelines

New treatment guidelines provide patients and their physicians with evidence-based recommendations for beginning antiretroviral therapy that take into account both the benefits and potential risks of currently available treatment regimens. The Guidelines for the Use of Antiretroviral Agents in HIV-Infected Adults and Adolescents were developed by the Panel on Clinical Practices for the Treatment of HIV Infection, a joint effort of the U.S. Department of Health and Human Services and the Kaiser Family Foundation. The guidelines were initially published in 1998, and are updated by the panel as new data emerges.

New guidelines recommend considering the start of antiretroviral therapy at higher levels of HIV in a patient's plasma than earlier guidelines suggested. Current guidelines continue to recommend antiretroviral therapy for all patients with acute HIV syndrome, those within six months of HIV seroconversion, and all patients with symptoms attributed to HIV infection.

The guidelines now include recent drug-specific recommendations. In addition, there are new sections including the importance of adherence to therapy, and an update on the expanding scope of antiretroviral drug toxicities.

The updated guidelines are available at <http://www.hivatis.org>. Single copies can be ordered by calling 1-800-448-0440, or by sending an e-mail request to atis@hivatis.org. &

Ryan White Grants for Primary Care

The Health Resources and Services Administration (HRSA) recently announced availability of new funding for the Ryan White Title III Early Intervention Services Program, which funds community-based organizations to provide outpatient primary care services for individuals with HIV.

HRSA also announced new funding for the Title III Planning Grant and Capacity Building Program which includes two different initiatives. The first initiative funds community-based organizations that are interested in conducting planning activities in order to improve their HIV primary care. The second is a new program which funds community-based organizations' expansion or enhancement of their organizational capacity to provide HIV primary care services. Pre-application workshops are planned throughout the spring. The deadline for the Early Intervention Services Program is projected to be July 2001. The deadline for the planning grants was June 1, 2001.

For more information, contact the Office of Minority Health Resource Center at 800-444-6472 or <http://www.omhrc.gov>, or go to <http://hab.hrsa.gov/grant.html>.

Acute Infection and Early Disease Research

The Division of AIDS within the National Institute of Allergy and Infectious Diseases is soliciting applications for the competitive continuation of a program to study the pathogenesis of acute or early HIV infection in adult humans, and to develop and evaluate the impact of therapeutic interventions at this early stage of the disease. This program was initiated under PAR-96-060, Acute Infection and Early Disease Research Network.

Each unit that receives an award will perform innovative, integrated, investigator-initiated pathogenesis, and clinical re-

search on acute and early HIV infection. Research will also place an emphasis on performing collaborative, multi-unit research projects as part of the Acute Infection and Early Disease Research Program. The multi-unit structure is required in order to enroll sufficient numbers of these difficult-to-identify acutely HIV-infected subjects for study.

Funding is available for up to 5 years. The letter of intent is due August 16, 2001. The application is due October 10, 2001. The intended award date is July 1, 2002.

For more information, call Linda Shaw, the application procedure contact person, at 301-402-6611 or e-mail lshaw@niaid.nih.gov. You may also call Frederick Batzold, the application technical information person, at 301-402-0413 or e-mail fbatzold@niaid.nih.gov.

Substance Abuse Prevention and HIV Prevention in Minority Communities

The Substance Abuse and Mental Health Services Administration (SAMHSA) recently announced funds for three Targeted Capacity Expansion Initiatives for Substance Abuse Prevention (SAP) and HIV Prevention (HIVP) in Minority Communities. Funds for the program are available to community-based organizations for expanding the capacity of their infrastructure necessary to providing sustained SAP and HIVP services in their communities. This can be achieved through the development of leadership, collaborations, coalitions, and partnerships.

This program responds to the health emergency in African-American, Hispanic/Latino, American Indian/Alaska Native, and Asian-American/Pacific Islander communities described by the Congressional Black Caucus. It includes three targeted initiatives:

- 1) Grants to establish new SAP and HIVP services in minority communities;
- 2) Cooperative agreements to expand current service delivery systems to in-

clude substance abuse prevention, HIV prevention, and primary health care services; and

- 3) Cooperative agreements to faith-based and youth-serving organizations to expand their youth service delivery to include effective integrated SAP and HIVP services.

The application receipt deadline for all three initiatives is July 10, 2001.

For a printed copy of the grant announcement, call the National Clearinghouse for Alcohol and Drug Information (NCADI) at 800-729-6686, or e-mail info@health.org. Application information is also available online at <http://www.samhsa.gov/grants/grants.html>.

CSAT American Indian/Alaska Native Community Planning Program

The Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration has announced funding for American Indian and Alaska Native (AI/AN) Planning Grants. These grants are to support community planning and consensus building, leading to the development of local substance abuse treatment system plans. The plans would describe how tribal governments and organizations that serve AI/AN communities will work together to deliver integrated substance abuse treatment and related services, such as HIV/AIDS prevention, mental health services, primary care, and other public health services.

This program is made up of two types of grants: Phase I (development) and Phase II (implementation). At this time, this announcement is for Phase I grants only. The application receipt deadline is July 10, 2001.

For a printed copy of the grant announcement, call the National Clearinghouse for Alcohol and Drug Information (NCADI) at 800-729-6686, or e-mail info@health.org. Application information is also available online at <http://www.samhsa.gov/grants/grants.html>.

Online Publications

Cultural Competence

American Journal of Nursing
<http://www.nursingworld.org/ajn/>

American Journal of Public Health
<http://www.apha.org/journal/>

Minority Nurse Magazine
<http://www.minoritynurse.com/about/magazine.html>

Migrant Farmworkers

Barriers to Health Coverage for Hispanic Workers: Focus Group Findings
http://www.cmwf.org/programs/minority/perry_barriers_425.pdf

Center for AIDS Prevention Studies AIDS Prevention Fact Sheets
<http://www.caps.ucsf.edu/FSindex.html>

Journal of Immigrant Health
<http://www.wkap.nl/jrnltoct.htm/1096-4045>

No Health Insurance? It's Enough to Make you Sick- Latino Community at Great Risk
<http://www.acponline.org/uninsured/lack-contents2.htm>

Youth

Assessing Health Risk Behaviors Among Young People: Youth Risk Behavior Surveillance System
<http://www.cdc.gov/nccdphp/dash/yrbs/yrbsaag.htm>

Guidelines for Effective School Health Education to Prevent the Spread of AIDS
<http://www.cdc.gov/nccdphp/dash/aids.htm>

Sex Education in America: A View from Inside the Nation's Classrooms
<http://www.kff.org/content/2000/3048>

The Young and the Restless
http://www.thebody.com/tpan/marapr_01/young.html

Organizations

Cultural Competence

Center for Cross Cultural Health
 Suite 100B
 1313 S.E. 5th Street
 Minneapolis, MN 55414
 612-379-3573
<http://www.crosshealth.com>

Cross Cultural Health Care Program
 1200 12th Ave. S.
 Seattle, WA 98144
 206-326-4161
<http://www.xculture.org>

Indian Health Service
 5600 Fishers Lane
 Parklawn Building, 6-35
 Rockville, MD 20857
 301-443-3593
<http://www.ihs.gov>

Resources for Cross Cultural Health Care
 8915 Sudbury Road
 Silver Spring, MD 20901
 301-588-6051
<http://www.diversityrx.org>

Migrant Farmworkers

The California Program on Access to Care
 2020 Addison Street
 Suite 202
 Berkeley, CA 94704
 510- 643-3140
<http://www.ucop.edu/cprc/>

Farmworker Justice Fund, Inc.
 Suite 1000
 111 19th Street, N.W.
 Washington, D.C. 20036
 202-776-1757
<http://www.fwjustice.org>

Health Education Training Centers, Alliance of Texas
 The University of Texas
 Health Science Center at San Antonio
 7703 Floyd Curl Drive
 San Antonio, TX 78284-7787
 210- 567-7800
<http://www.uthscsa.edu/HETCAT/>

National Center for Farmworker Health

P. O. Box 150009
Austin, TX 78715
512-312-2700
<http://www.ncfh.org>

Rural Center for AIDS/STD Prevention

Indiana University
801 East Seventh St.
Bloomington, IN 47405-3085
812-855-1718
<http://www.indiana.edu/~aids/>

Youth***Administration for Children and Families***

370 L'Enfant Promenade S.W.
Washington, DC 20447
202-401-9215
<http://www.acf.dhhs.gov>

American Academy of Child and Adolescent Psychiatry

3615 Wisconsin Ave., N.W.
Washington, D.C. 20016-3007
202-966-7300
<http://www.aacap.org>

Child Welfare League of America

440 First Street NW, Third Floor
Washington, DC 20001-2085
202-638-2952
<http://www.cwla.org>

National Adolescent Health Information Center

3333 California Street
Box 0503
San Francisco, CA 94143-0503
415-502-4856
<http://youth.ucsf.edu/nahic>

National Pediatric & Family HIV Resource Center

University of Medicine & Dentistry of New Jersey
30 Bergen Street - ADMC #4
Newark, NJ 07103
800-362-0071
<http://www.pedhivaid.org/>

The Sexuality Information and Education Council of the U.S (SIECUS)

130 West 42nd Street,
Suite 350
New York, NY 10036-7802
212-819-9770
<http://www.siecus.org>

Publications

Guidelines for the Care of Migrant Farmworkers' Children, developed by the American Academy of Pediatrics and the Migrant Clinicians Network, is a manual that will serve as a comprehensive guide for practitioners in the communities serving the children of migrant and seasonal farmworkers. It will also be useful in community settings that serve as training sites for medical students, residents, and other health professionals.

The American Academy of Pediatrics
141 Northwest Point Boulevard
Elk Grove Village, IL 60007-1098
847-434-4000
<http://www.aap.org>

Guidelines for the Use of Antiretroviral Agents in HIV Infected Adults & Adolescents recommends that care should be supervised by an expert, and makes recommendations for laboratory monitoring including plasma HIV RNA, CD4 cell counts, and HIV drug resistance testing. The report also provides guidelines for antiretroviral therapy, including when to start treatment, what drugs to initiate, when to change therapy, and therapeutic options to consider when changing therapy.

HIV/AIDS Treatment Information Service
P.O. Box 6303
Rockville, MD 20849-6303
800-HIV-0440 (1-800-448-0440)
<http://hivatis.org/>

HIV and AIDS in Children: Questions and Answers addresses basic questions about epidemiology, treatment, and care of children with HIV.

National Pediatric & Family HIV Resource Center
University of Medicine & Dentistry of New Jersey
30 Bergen Street - ADMC #4
Newark, NJ 07103
800-362-0071
973-972-0410
<http://www.pedhivaid.org/index.html>

A Provider's Handbook on Culturally Competent Care: Lesbian, Gay, Bisexual and Transgender Population summarizes research, suggests the implications of that research for providers, provides a model intake form, and offers patient interview suggestions.

Kaiser Permanente National Diversity Council
#1 Kaiser Plaza, 20th Floor
Oakland, CA 94612
510-271-6485

HIV Impact

Upcoming Conferences

June

- 8-10: *Helping Communities Build Leadership Training*. To be held in Memphis, TN. Sponsored by the National Association of People with AIDS. Contact: Joseph Lovato at 202-898-0414, ext.121; Website: <http://www.napwa.org>.
- 10-12: *Research to Action: Shaping Our Health Care Future*. To be held in Atlanta, GA. Sponsored by the Academy for Health Services Research and Health Policy. Contact: 202-292-6700; Website: <http://www.academyhealth.org>.
- 14-17: *Opening Doors and Rebuilding Lives: 4th National HIV/AIDS Housing Conference*. To be held in Denver, CO. Sponsored by AIDS Housing of Washington. Contact: 206-441-3166; Website: <http://www.aidshousing.org>.

22-24: *Leadership Training Institute*. To be held in Pittsburgh, PA. Sponsored by the National Association of People with AIDS. Contact: Charles Debnam at 202-898-0414, ext. 127; Website: <http://www.napwa.org>.

~~27-28~~: *HIV Prevention Counseling: The Fundamentals*. To be held in Fairfax, VA. Sponsored by the Inova Juniper Program. Contact: 703-204-3780; Website: <http://www.inova.org>.

July

9-13: *Multidisciplinary HIV/AIDS Preceptorship Program*. To be held in Washington, D.C. Sponsored by the National Minority AIDS Education and Training Center at Howard University. Contact: 202-865-3300 for more information and additional dates; Website: <http://www.nmaetc.org>.

16-18: *6th Annual National Prevention Institute*. To be held in San Diego, CA. Sponsored by the Comprehensive Health Education Foundation. Contact: 800-323-2433; Website: <http://chef.org>.

August

12-15: *2001 National HIV Prevention Conference*. To be held in Atlanta, GA. Sponsored by Centers for Disease Control and Prevention (CDC). Contact: 404-233-6446; Website: <http://www.2001hivprevconf.org>

16-19: *Staying Alive - In The Spirit*. To be held in Chicago, IL. Sponsored by the National Association of People with AIDS. Contact: Charles Debnam at 202-898-0414, ext. 127; Website: <http://www.napwa.org>.

September

13-16: *United States Conference on AIDS 2001*. To be held in Miami Beach, FL. Sponsored by National Minority AIDS Council (NMAC). Contact: Paul Woods at 202-483-6622, ext 343; Website: <http://www.nmac.org/usca2001/home.htm>