

ENTRE FAMILIA:

Addressing the Interconnected Issues of
California's Latinos and HIV in Education, Prevention, Care and Treatment

A Report of the Latino Advisory Board

Presented to the
State of California
California Department of Public Health
Office of AIDS

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About the Latino Advisory Board (LAB) and this Report

In 1998, two community meetings were held with Latinos in California. To fully encompass the state's Latino population, one meeting involved rural communities and the other involved urban communities. These meetings were designed as strategy sessions with the purpose of discussing and identifying ways to increase awareness of HIV/AIDS in the Latino community. In 2000, the California Department of Health Services*, Office of AIDS (CDHS/OA) held a conference entitled, "Hoy, Mañana, y el Futuro – HIV Latino Summit" to further address these issues. The LAB was established in 2003 to work directly with CDHS/OA to examine and address HIV/AIDS prevention, care, and research issues in the Latino community in California. LAB was tasked with identifying gaps in health care services and making recommendations to the HIV Education and Prevention Services Branch, HIV Care Branch, and HIV/AIDS Epidemiology Branch of CDHS/OA for policies, research, and programs. During its meetings, LAB members reviewed the results of previous research and drew on their own experience working in various Latino communities; additional research was conducted specifically for this report.

Office of AIDS staff have supported the development of this report by convening meetings, providing data, and reviewing, editing and providing content recommendations on draft reports. However, all analysis, opinions, and recommendations are those of the LAB alone, and do not necessarily represent analysis provided by, nor the position of, the Office of AIDS. Office of AIDS staff are committed to periodic review of the recommendations contained within this report and ongoing dialogue with relevant stakeholders regarding these and other existing and subsequent recommendations.

*The California Department of Health Services was split into two separate departments in 2007. The Office of AIDS now resides in the California Department of Public Health (CDPH).

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Executive Summary

This report includes a general introduction to the complex HIV/AIDS-related issues faced by Latinos in California, the status of the state's Latino community 25 years into the HIV/AIDS epidemic, and recommendations to the California State Department of Public Health, Office of AIDS (CDPH/OA). The goal of this document is to provide a foundation for practical steps to address HIV/AIDS-related issues facing Latinos in California.

Related reports and policy recommendations have been published, most notably *Addressing HIV/AIDS: Latino Perspectives and Recommendations* from the National Alliance of State and Territorial AIDS Directors (NASTAD).¹ In 2004, with funding from the Los Angeles County, Office of AIDS Programs and Policy and other private sources, the Latino Coalition Against AIDS convened "Strategies for an Evolving Epidemic: A Latino HIV Policy Summit." Its "HIV/AIDS in Latino Communities: A Blueprint for Action" outlined recommendations for possible initiatives and/or public policy responses to address the increasing rates of HIV infection among Latinos. This report, "*Entre Familia: Addressing the Interconnected Issues of California's Latinos and HIV in Education, Prevention, and Treatment*," is specifically designed to be a companion piece to the nationally-focused NASTAD publication, with a special focus on health issues among Latinos in California.

While identifying the title for this document, the LAB discussed a number of possibilities to unify the recommendations set forth in this report. Central to the discussion was the need to include the theme of *familia* (family). While Latinos are a large and diverse population, *familia* is a unifying component that moves across all Latino populations. Clearly, as any HIV/AIDS professional addresses education, prevention, care and treatment needs for Latinos, the importance of *familia* is a cultural value to be considered. Hence, the title, "*Entre Familia*," or Amongst Family, is a report written by *familia* to benefit *familia* in the struggle against a disease that continues to affect the entire Latino family in California.

As the LAB reviewed and analyzed data leading to its recommendations, the LAB was overwhelmed by the magnitude of challenges and struggles Latinos face in accessing healthcare. Limitations to healthcare, combined with the stigma of HIV, make quality HIV/AIDS prevention, care, and treatment even more difficult to achieve. While the LAB understood the importance of developing recommendations that were achievable by CDPH/OA, it could not help but bring to light challenges that are only resolved by changes in national public health policy. For example, ***Recommendation #6, Strengthen and expand international collaborations and partnerships***, may require the collaboration of four major jurisdictions: two countries, the United States and Mexico; two border states California and Baja California; two United States counties; and the Mexican cities of Tijuana and Mexicali. In this example the LAB understands California's jurisdictional limitations in achieving *Recommendation #6*, yet believes that as California continues to work towards a solid Latino HIV/AIDS prevention, care and treatment plan, it should bear in mind the impact of the Latino transborder population on public health in California.

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Below is the list of the eight LAB recommendations, followed by narrative that describes the current state of the HIV/AIDS epidemic in the Latino community, the risk factors, barriers to care, and finally a detailed description of the recommendations.

Recommendations for State of California Department of Public Health, Office of AIDS Consideration

1. Revise categories of analysis and service provision to reflect significant socio-economic and cultural differences throughout California.
2. Develop Latino leadership to assure that Latinos of various backgrounds are integrated into HIV planning processes; develop community organizers for mobilization.
3. Develop and implement culturally and linguistically competent models for HIV prevention and care that identify socio-economic, geographic and cultural differences among Latinos throughout California.

Relevant for State, National, and International Partner Consideration

4. Support and expand local, national, and bi-national research to address HIV/AIDS in Latino communities.
5. Strengthen and expand international collaborations and partnerships.
6. Address homophobia, transphobia, stigma, and silence. Expand efforts to make HIV less stigmatized and promote accurate information about HIV and AIDS in Latino communities.

Relevant for National and International Partner Consideration

7. Improve access to prevention, care, and treatment services for Latinos in California regardless of their immigration, citizenship, or insurance status.
8. Assess the effectiveness of the American medical system on Latinos born outside the United States and differences in attitudes among Latinos towards health and health care.

Section I. Background

Latinos in California

The vast majority of Latinos in California are either United States citizens or legal residents. The U.S. Census Bureau reports that among Mexican Americans, 85 percent are either U.S. citizens or legal residents.² Generations of Latinos have lived in California (so named since 1825 when it was still a property of Mexico). There are 4.9 million Latinos in California who are foreign-born, while approximately 60 percent of the Latinos in California are citizens.³

Farm workers, over 90 percent of whom were born in Mexico, remain among the lowest paid workers in California, despite the fact that the state's agriculture is a \$28 billion a year industry. Throughout the state, Latinos overwhelmingly work in blue-collar jobs, with less than 10 percent of Latinos in managerial and professional occupations.⁴

Latinos are the largest minority group in California, comprising 32 percent of the total population.² Mexican nationals and Mexican Americans are the most numerous and visible of all 11 million Latinos in California² as well as the largest segment in a group composed of a mix of ethnicities and cultures. According to a fact sheet distributed by the National Council of La Raza, the largest percentage of Latinos are of Mexican heritage, followed by Central and South Americans, Puerto Ricans, Cubans, and Dominicans. Among Mexican immigrants, an increasing number are indigenous peoples, including Mixtec, Zapotec, and Triqueño, many of whom are not fluent in English or Spanish.

Between 1990 and 2000, the population of California increased by about six million residents. Latinos accounted for nearly 55 percent of the state's population growth over the last decade. Three of the top ten U.S. metropolitan areas with the largest Latino populations in California are Los Angeles (45 percent), Riverside-San Bernardino (38 percent), and Orange County (31 percent).⁵ Between 1980 and 2000, Los Angeles' Latino population grew 105 percent, Orange County's Latino population tripled, and Riverside-San Bernardino's Latino population grew by over 300 percent. In the Cities of Oakland, Bakersfield, Sacramento, San Diego, Stockton, and Vallejo, the Latino populations grew by an average of 170 percent in these 20 years.

California's Latino youth (ages 10 to 19 years) was estimated to be 2.4 million in 2005, up from 1.5 million in 1995.⁶ According the California Department of Education, in the 2005-2006 school year, Latinos represented 45 percent of kindergarten through twelfth graders in public schools.

The Current State of the HIV Epidemic in California and Nationwide

Latino representation among AIDS cases is higher in California than in the United States. Latinos comprised 22.6 percent of AIDS cases diagnosed in California through 2005, compared to 15.8 percent nationwide.⁷ This difference has increased in recent years. Among cases diagnosed in 2005, the Latino composition in California was 36.3 percent compared to 18.5 percent nationally.⁷

While the vast majority of Latino AIDS cases are male both statewide and nationwide, the proportion of females has steadily increased. In the United States, females comprised 14.6 percent of Latino AIDS cases diagnosed in 1990 but 22.1 percent in 2005.^{7,8} In California, surveillance data show that the percentage of females among Latino AIDS cases has risen from less than two percent prior to 1985 to over 12 percent each year since 2000. About one-third of female AIDS cases diagnosed in California since 2000 are Latina.

The most commonly reported modes of HIV exposure among male and female Latino AIDS cases in California involve sexual transmission. Nearly 70 percent of male Latino AIDS cases have been reported in the HIV risk category of men who have sex with men.⁹ Fifty-six percent of Latina AIDS cases were infected with HIV through heterosexual contact, while 20 percent were infected through injection drug use.⁹ Exposure due to heterosexual contact was most prevalent for Latinas between 20 to 29 years of age, representing 65 percent of cases in this age group.⁹ Exposure due to injection drug use was most prevalent among Latinas aged 40 to 49.⁹

There have been remarkable improvements in the prevention of perinatal transmission of HIV. Of the over 540,000 babies born in California each year, it is estimated that less than five are infected with HIV via perinatal transmission. In order to eliminate those last five transmissions, California has aggressively pursued solutions that will continue to reduce mother-to-child (MTC) HIV transmission. In January 2004, Assembly Bill 1676 (Dutra) went into effect. This law requires that all mothers be told during prenatal care they will receive an HIV test with their other prenatal blood tests unless they refuse the HIV test. Testing pregnant women during prenatal care and treating HIV-positive pregnant women with antiretroviral therapy effectively reduces MCT HIV transmission from 25 percent to less than two percent.

There is a growing awareness of the impact that HIV/AIDS is having on the Latino transgender male to female (MtF) community. Researchers have described alarming levels of HIV/AIDS and unmet prevention efforts, research and the lack of health care access for Transgender Latinas. According to the report "Focus Summary: Latino/a Contacts" Transgender Latinas had the highest percentage (3.2%) of positive results among testers at California publicly funded C&T sites.⁴¹ HIV rates among transgender Latinas ranging from 26% to 29% have been documented in Los Angeles and San Francisco.^{42,43} According to Organista "Service providers and researchers working with transgender people believe that they may be at greatest risk for the long list of vulnerabilities that result from pervasive oppression or transphobia".⁴⁰ In a recent tragic example of institutional stigma, Victoria Arellano, a 23 year old transgender Latina was denied HIV care and treatment while in custody in an Immigration and Customs Enforcement (I.C.E) facility and died shackled to her detention bed.⁴⁴

In a national survey conducted in 2000 by the Henry J. Kaiser Family Foundation, participants were asked through an open-ended question to identify the number one health issue

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facing the nation; 40 percent of Latino respondents replied, "AIDS." When asked specifically about HIV/AIDS, 64 percent felt it was a more urgent problem facing the nation than a few years ago.¹⁰ Disturbingly, 69 percent of all Latinos say AIDS is a serious problem for people they know,¹⁰ and 81 percent of Latinos whose primary language is Spanish believe it is a "very" serious problem for someone they know.¹⁰

Latino Risk Factors for HIV/AIDS: Barriers to Accessing Care

There are many risk factors and co-factors for HIV/AIDS; conditions that increase the risk of becoming infected with HIV, or increase the chances of developing AIDS. Most of the factors outlined below are true for all peoples regardless of ethnic or cultural origin. This section addresses those conditions disproportionately affecting Latino communities, elaborates on the particular impact of these factors for Latinos, and discusses risk factors that are unique to these communities.

Cultural differences in approaches to health care: United States, Mexico, Central, and South America

A patient's willingness to accept an HIV or AIDS diagnosis and subsequently comply with recommended treatment is likely to be at least partially dependent upon his or her agreement with the provider's analysis. In LAB members' experience, a majority of Latino clients from Central and South America are accustomed to a system that involves receiving personal attention quickly, minimal recordkeeping, limited laboratory testing, and fast acting (symptom-based) treatments. The formalized health care systems in the United States are perceived as alienating, cumbersome, and slow by comparison. In both cultures, it is normal for people to self-diagnose and purchase over-the-counter medicines to treat symptoms. However, among the more recently arrived, lower income, and trans-border populations, this behavior can extend to more severe or chronic conditions, the purchase of non-prescribed pharmaceuticals, and seeking symptom-oriented treatment in Mexico.¹¹ Some immigrants who have U.S. health insurance still return to Mexico for health care because services are less expensive and the style of treatment is more culturally familiar.¹¹

Another facet of traditional Latino health care is ascribing a spiritual or mental cause as the root of an illness. In the United States, this type of practice is often scoffed at as "hypochondria" or "paranoia." Most medical training programs in the United States do not prepare a physician to hear that the patient is seeking medical care because they have *nervios* (anxiousness), *susto* (fright), or *empacho* (digestive distress). Without appropriate training, physicians are not only unprepared, they can be dismissive of the Latino patient's very real sense of illness. This in turn may erode the patient's faith in the physician and reduces the likelihood of follow-up visits.¹¹ A survey of California farm workers found that some make a distinction between the ability to diagnose and the ability to heal, believing that doctors can analyze diseases and diagnose illnesses, but are less skilled at curing those conditions. For cures, persons with these perceptions turn to *curanderos* (folk medicine specialists who administer therapies based on ritual cures).

A key conclusion from LAB meetings is that Latino clients are likely to seek health care and prescriptions on both sides of the U.S.-Mexico border. This is true for Latinos throughout the state, not just those from the border region.

Access to Regular/Quality Health Care

Good health is dependent upon access to quality health care. Such access is particularly critical when considering potentially chronic or treatment-intensive conditions such as AIDS and related risk factors including substance use/addiction, hepatitis, and tuberculosis.

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In the United States, access to most forms of health care is dependent upon having some form of health insurance. Additionally, several studies have identified insurance status as a key predictor in the quality of care a patient receives.¹² The high uninsured rate for Latinos, nearly twice the rate for non-Latinos,¹³ is significantly linked to a lack of employer-based coverage. Nationwide, 73 percent of Whites and only 43 percent of Latinos have health care insurance through the workplace.¹³ This discrepancy is partially explained by the number of low-wage workers within the Latino community. Despite popular misconceptions, the majority of uninsured Latinos come from working families (87 percent).¹⁴ Even with this high rate of employment, nearly 60 percent of Latinos nationwide live in families with incomes below 200 percent of the poverty level, compared with 23 percent of non-Hispanic White persons. In general, low-wage workers are less likely to be offered health benefits, or are unable to afford the employee's share of premiums when they are offered coverage. In every type of industry, Latinos are considerably less likely than non-Hispanic White persons to have employer health benefit coverage.¹³

According to the March 2000 Current Population Survey, Latinos constituted 72 percent of eligible but uninsured children in California. Four in ten Latinos living in poverty depend on Medi-Cal; however, welfare reforms and changes in Medi-Cal eligibility for legal immigrants have decreased the number of Latinos covered by Medi-Cal. Legal residents entering the United States after 1996 are generally not eligible for Medicaid¹⁴ and those who are eligible may be reluctant to apply due to fears of jeopardizing future citizenship or being forced to repay medical costs. Between 1994 and 1997, Medicaid coverage of Latinos declined from 20 percent to 16 percent, despite an increase in job-based coverage during this same period (40 percent to 43 percent).¹⁵

Latinos are the least likely among all ethnic groups to have a specific provider to access health care. One-quarter of Latino adults (and nearly half of uninsured Latino adults) have no usual source of care. Uninsured Latino children are twice as likely as non-Hispanic White children to have no usual source of care (32 percent versus 16 percent). These disparities are found almost entirely among the uninsured; having private or Medi-Cal coverage increases the likelihood of having a usual source of care and eliminates most ethnic disparities.¹⁵

The uninsured rate is particularly acute among farm workers, a population which is contending with multiple issues such as poverty, malnutrition, infectious diseases, and poor housing. These stresses in turn contribute to high rates of depression and substance use. In a 1999 health survey of agricultural workers in this state (California Agricultural Workers Health Survey [CAWHS]), nearly 70 percent of the respondents lacked any form of health insurance.¹⁶ Nearly one-third of the 16.5 percent who were offered health insurance said that they either could not afford the premiums or could not afford the co-payments for treatment and so did not enroll.¹⁶ When asked to describe their most recent visit to a doctor or clinic, 32 percent of the male CAWHS respondents said that they had never been to a doctor or a clinic.

The rates of uninsured are significant in an HIV/AIDS context for numerous reasons. First, individuals who are uninsured are more likely to be unaware of their HIV status until late in their HIV disease progression. Second, uninsured HIV-infected persons are unlikely to be able to enter into and/or maintain an effective and expensive treatment regimen. Lastly, individuals who are uninsured frequently have other health issues that can accelerate the progress of HIV disease, such as tuberculosis, other sexually transmitted diseases, and diabetes.

Underutilization of available services

A 2003 survey by CDPH/OA on language preferences of AIDS Drug Assistance Program (ADAP) users in California revealed that 12 percent of clients who preferred Spanish fell far short of the U.S. Census results of 26 percent for Spanish language preferences. This is of particular concern because: (1) ADAP is a major resource for HIV-infected people of limited income and who do not have health insurance;¹⁷ (2) individuals who do not speak English well are more likely to be uninsured; and (3) individuals with limited English skills may have a higher risk for HIV. ADAP should be a key resource for Spanish-speaking HIV-positive Latinos California, but CDPH/OA data suggests that this population may be underutilizing ADAP.

Distribution of services: Rural

Health care providers in rural areas recognize that transportation to available services is a significant challenge for lower-income rural populations. To reduce this barrier, various community-based organizations, health centers, and other providers try to either position their services within the communities they are trying to serve, or provide transportation for their clients. The latter is nearly impossible among widely-dispersed agricultural worker populations. Services in rural areas are limited or frequently far away, essentially inaccessible to low-income individuals who lack personal transportation, and work in jobs that do not allow them to take sick days for health care reasons. Even when access is available, low-income individuals may believe taking time off work is not economically affordable.

Efforts to address the transportation needs of rural farm workers have included the provision of mobile vans to provide screenings and immediate care, including one funded by CDPH/OA specifically to provide HIV counseling and testing, primary care, and dental services in five Northern California counties. These services are often the farm workers' first contact with the U.S. medical system. More services like these are necessary, but must be integrated into the larger system to avoid fragmentation of health care.¹¹ Mobile vans are an invaluable service and can help address some health care issues before they become serious, but these limited services do not address the types of treatment provision and monitoring that are necessary for such chronic conditions as HIV, tuberculosis, substance abuse, and diabetes.

Distribution of services: Suburban

The Latino population has greatly expanded within suburban areas in the last ten years. Generally, services for Spanish-speaking populations are less abundant in these areas, and services in indigenous Latino languages are nearly non-existent. Recent immigrant populations may also be less mobile than many of their suburban counterparts, and unlikely to seek services in their related urban centers. It is important to conduct new research into the needs of this population and generate services accordingly.

Poverty

Studies have shown that poverty may lead to higher risk for HIV infection and a faster progression to AIDS among Latinos.^{18, 19} Low-income individuals overall tend to have poor health outcomes and increased rates of HIV co-factors such as decreased access to health care, lower level of education, and increased risk of substance use.

Latinos are among California's poorest residents. According to the 2000 U.S. Census, Latinos ranked second lowest in both family income and per capita income.²⁰ Considering that 97 percent of U.S. Census survey respondents of "Some Other Race" also responded

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“Hispanic,”²¹ these figures describe a more troubling situation. In a national survey, half of all Latinos reported annual incomes under \$30,000, while about two-thirds of all Latinos who predominately spoke Spanish reported making less than \$30,000 annually.²¹

Latino labor migrants

California's 700,000 agricultural workers, of which 96 percent are Hispanic, are among the poorest workers in the state. In 1999, a large-scale survey conducted at five of the state's six agricultural regions found that the median annual earnings for agricultural workers were between \$7,500 and \$9,999.¹⁶

Racial and Ethnic Bias in Health Care

Many of the disparities in quality of health care may be linked directly to the high uninsured rates among Latinos or to the overall severity of disease at the time of treatment. However, several studies have demonstrated that when these factors are removed, race and ethnicity remain significant predictors of quality of care.¹³

Impact of external discrimination on provider/patient relationship

Although some health care providers offer culturally competent care, many patients come to providers with expectations of discrimination based either upon previous health care experiences or on prejudiced treatment in more general settings. These experiences, whether real or perceived, will likely affect the patient's expectations, attitudes, and behaviors towards both the provider and the health care system.¹²

HIV/AIDS Stigma, Misperceptions, and Misinformation

Levels of knowledge about HIV transmission vary greatly among Latinos. A national survey found that nearly all younger Latinos understood the basic facts about HIV transmission. However, among Latinos above the age of 30, over 50 percent thought that kissing was a potential route of transmission, as was touching a toilet seat (34 percent), and sharing a drinking glass (30 percent).¹⁰ Among Latino gay men, researchers have found a generally high level of knowledge about safer sex techniques and routes of HIV transmission.²² However, more than one-third of Latinos (34 percent) think that a vaccine is available to prevent HIV or are not sure if one exists.¹⁰

Latinos whose primary language is Spanish are significantly more likely to have misconceptions about the risk of HIV infection through casual contact. In a national survey, 56 percent of individuals interviewed in Spanish thought kissing could result in HIV infection and 32 percent believed sharing a drinking glass is a route of transmission, compared with 39 percent and 18 percent of those interviewed in English.¹⁰

HIV stigma is prevalent in the Latino community. Thirty-six percent said they would be “very” or “somewhat” concerned that people would think less of them if they found out they had been tested for HIV regardless of test result.¹⁰ When asked if, in general, they felt there was prejudice and discrimination against people living with HIV/AIDS in the United States today, 85 percent of Latinos responded “yes.”¹⁰ Latinos with more education are more likely to fear being stigmatized for HIV issues than those with less education.

Machismo

Latino culture is permeated with a “cult of virility” or “cult of manliness.”²³ This *machismo* is often cited as a key piece of the psychological makeup of Mexican men, particularly among those who have little or no education, and those who are less acculturated to American society. It is often perceived negatively, and is associated with domination over women, selfish behaviors, sexual promiscuousness, and the unwillingness to ask for help at any time lest one's masculinity be called into question.²³

This sense of *machismo* can contribute to increasing HIV risk by promoting multiple sexual partners, reinforcing underlying homophobia, and decreasing the likelihood that men will ask for assistance even if they were to become ill. Diaz and Ayala found that Latino gay men associated the inability to control themselves in sexual situations, in part, with the basic nature of masculinity.²² Men who had engaged in unprotected sex did so with full knowledge and understanding of HIV transmission, but felt that being concerned about protection was at odds with sexual arousal

In addition, high levels of traditional gender role beliefs (e.g. “*machismo*”) among Latino men may have a negative impact on Latino women, as they have the potential to condone coercive sexual practices.²⁴

Substance Use/Abuse

Injection drug use is the second highest route of transmission for Latino men and women in California.⁹ In 2002, 30 percent of all people admitted for substance abuse treatment in California were Latino.²⁵ In addition, Latino men comprise over one-third of all men incarcerated on drug charges in California.²⁶

Latino youth have particularly high substance use rates and are likely to start drinking at a younger age than either White or African American youth to drink alcohol.²⁵ Among Latino high school students, nearly 25 percent report current marijuana use.²⁵ While neither alcohol nor marijuana use is a direct route of HIV transmission, both have been linked with increased rates of risk behaviors known to transmit HIV. A survey of empirical studies found that Latinos born in the United States are more likely than immigrants to use illicit drugs.²⁷

Incarceration

According to 2000 U.S. Census data, Latinos comprise 32 percent of California's population but over one-third of prison inmates in the state.²⁸ According to the U.S. Department of Justice, Latino men are four times more likely than White men to be incarcerated in a state or federal prison at some point in their lives.²⁹

Incarceration carries with it additional health risks. In one study of California prison inmates, 36 percent of Latinos were found to be infected with hepatitis C, compared with two percent in the overall population of California.³⁰

Religion

The majority of Latinos in the United States are Roman Catholics, although this proportion varies between those U.S.-born (59 percent) versus foreign-born (76 percent).²¹ More native-born Latinos identify themselves as Evangelical or Born-Again Christian than immigrant Latinos (20 percent and 11 percent, respectively).²¹ Mexicans are most likely to be Catholic (76 percent) and Salvadorians the least (52 percent).²¹ Less than 10 percent of all Latinos state they have no

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religion, but this rate varies among groups, with 15 percent of Salvadorians, 14 percent of Cubans, and only 6 percent of Mexicans claiming no religion.

Religious preference is important in the context of HIV in that it is strongly related to the values that Latinos hold. Roman Catholics, Evangelicals, and those who are Born-Again are generally more socially conservative than those who claim no religious preference. In the HIV context, a survey showed that 72 percent of all Latinos felt that "sex between two adults of the same sex" was "unacceptable."²¹ The Roman Catholic Church has also taken a strong stand against condoms and all forms of birth control, a position that has an impact on Catholics from Latin and South America.

Education

Education level is a key predictor of future income, which is in turn linked to overall health outcomes, health care access, and likelihood of contracting HIV. Key differences exist between immigrant and U.S.-born Latinos' level of education, suggesting that different strategies must be employed to address this issue within each community.

School drop-out rates

While the drop-out rate for Latino youth aged 16-19 is more than twice the average for Whites (15 percent compared with 7 percent), 18 percent of immigrant Latino youth overall drop out, and those who were born in Mexico are leaving high school at the rate of 39 percent prior to graduation.³¹ Teens of Mexican-origin born in the United States also have a drop-out rate of 15 percent, compared with 3 percent for teens of Central American descent. Among immigrants, South Americans have the lowest drop-out rate (13 percent).³¹

Language Issues

Language creates an additional barrier to accessing health care for many Latinos. Many health care facilities in California have bilingual Spanish/English staff or have ready access to Spanish translation, but a significant percentage of Latinos speak neither Spanish nor English. This population speaks only a language indigenous to their region of Mexico (i.e., Chihuahua and Oaxaca) that is not supported in most health care and educational settings. Outreach efforts into these communities have been severely hampered by the lack of a common language and by the general distrust of anyone who is from the outside.³²

Educating California's Spanish-speaking students continues to be a challenge for public education. According to Jepsen and de Alth (2005)³², of the 1.4 million English-language learners in California, 85% speak Spanish. Spanish speaking children tend to come from families with low levels of parental education and income. Schools that have a student body of low-income children do not perform as well on statewide assessments as children from more affluent schools.

Illiteracy increases the risk for poverty, which is correlated with increased risk for HIV. Literacy can also affect an individual's ability to get and maintain appropriate treatments. The ability to read is a critical factor in an individual's ability to navigate a complex medical system, and to read basic information about prescribed treatment schedules. Predictably, individuals with limited education are less able to understand the various options available to them, or to make informed decisions about their own health. Nearly all (90 percent) immigrant Latino youth who were educated abroad dropped out of high school. This is even more striking when

compared with the 15 percent high school drop-out rate of immigrant youth who have spent some time in the U.S. school system.³²

Stigma Attached to Being Gay

Gay and bisexual Latinos face significant cultural barriers that affect both their ability to “come out” and their self-image. The sense of *machismo* pervasive throughout Latino culture can include “accusations” of being either homosexual or bewitched if a man does not demonstrate a strong sense of masculinity. The Roman Catholic Church plays a strong role in Latino culture, and its’ socially conservative positions include opposition to homosexuality. Some researchers hold that the continual message that gay people will be punished for their sins, linked with an underlying sense of fatalism embedded within Latino culture, has been used as a justification for unsafe sex by Latino gay men.²² These men feel that they are leaving their fate, the results of their actions, in the hands of God.

Latino men and women are heavily pressured to get married and have children, a burden which can be especially hard on a gay man who feels responsible for carrying on the family name. A strong culture of *familismo*, in which family identity takes precedence over individual identity, lends an additional stress that can lead to negative mental health outcomes including depression, isolation, and shame. These same mental health conditions have been strongly correlated with increased HIV/AIDS-related risk-taking behavior.³³

It is well established that increased mental stress increases the likelihood of practicing unsafe sex. Diaz has specifically examined this within communities of Latino men who have sex with men.³⁴ These studies show that Latino gay men who faced high levels of homophobia, racism, and poverty were more likely than those reporting lower levels to have engaged in unprotected anal intercourse with a non-monogamous recent partner. Conversely, these studies have found that family acceptance and having a gay role model while growing up significantly increased self-esteem, and decreased the likelihood that these Latino gay men would be in a high-risk situation.³⁴

Transgender Latinas

Transgender people experience a mismatch between their biological sex and their gender identity. Male-to-male (MTF) and female-to-male (FTM) transgender people feel more congruent with the gender identities, roles and or appearance of the opposite sex, whether or not they pursue hormonal treatment or reassignment surgery. If providers and others in society are capable of relinquishing their biased socialization regarding transgender people, and are able to recast them as fully human and thus deserving of full human rights, figuring out the rest of the human diversity puzzle should be easy. Part of the challenge resides in the dilemma that transgender people are not only stigmatized and rejected by heterosexuals, who frequently perceive them as homosexuals, but they have also been historically stigmatized by gays and lesbians, and not welcomed into traditional gay and lesbian care settings.⁴⁰

High Mortality Rate

As of 2001, AIDS was the third leading cause of death among Latinos aged 25-44 in the United States.³⁵ This reflects not only relatively high infection rates among Latinos, but also the reality that Latinos diagnosed with HIV often die from AIDS more quickly, despite an overall decline in AIDS-related deaths nationwide. This high mortality rate is due to a number of

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possible factors, including: late diagnosis, lack of access to HIV testing or proper HIV treatments, and the inability or unwillingness to engage in rigorous HIV treatment.

Nearly half of all Latinos (46 percent) and Latinas (44 percent) diagnosed with AIDS from 1990-1999 were diagnosed late in their illness.³⁶ This corresponds to an AIDS diagnosis within one year of first testing positive for HIV antibodies. Because HIV treatments may be less effective when introduced late in disease progression, this may impact the survival rate of HIV-infected Latinos. Late diagnosis is directly related to a high mortality rate.

Fatalism

Many HIV prevention and treatment efforts hinge on motivating individuals to take better care of themselves. In situations where populations are more communally motivated, the message changes to one of taking care of others. In either context, however, such messages are impractical if an individual believes that any action taken will not change one's overall fate. This sense of fatalism is predominant among less acculturated Latinos. Over half of immigrant Latinos who arrived in the United States after the age of ten and predominantly speak Spanish believe that "it does no good to plan for the future because you don't have any control over it" (55 percent and 59 percent, respectively).²¹ However, this view is not limited to only the less acculturated: 42 percent of all Latinos surveyed agreed with this statement, as compared with 15 percent of Whites.²¹

Diaz and Ayala found this attitude specifically used as a justification for engaging in unsafe sex by Latino gay men in the United States. According to study participants, "Latinos are supposed to enjoy life in a carefree manner and leave consequences in the hands of God."²² The authors felt that this "rebellion" of engaging in unsafe sex became, "the most proactive and effective responses against feelings of helplessness" arising from a sense that contracting HIV was inevitable.²²

Acculturation

As discussed in the NASTAD document,¹ studies of the impact of acculturation on Latino health and well being have presented contradictory results. Individuals with higher English language and education skills are more likely to have higher incomes, to have health insurance, and to receive an overall higher quality of health care. However, some studies have linked a higher level of acculturation with an increased sense of isolation, dissolution of support networks, and an overall risk of depression, all conditions linked with an increased risk of HIV. A stronger sense of individualism that accompanies becoming more "Americanized" could potentially lead to increased risk taking or to a greater ability to have self-determination, a decrease in stress around being gay as a result of distance from the original strongly homophobic culture, or an increase in stress resulting from a sense of having failed or abandoned the family.

Acculturation levels cannot predict mental or physical health. Understanding the complex stresses experienced by an increasingly acculturated population, however, can help give insight into these seemingly contradictory conditions. The push to improve the English-language skills, the overall education level, and the level of involvement in key decision-making processes of Latinos (e.g., in HIV policy planning groups) should be undertaken with the knowledge that acculturation has a complex impact on individual lives.

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Familismo

The Latino culture is communally-minded, and this is very evident in *familismo*, the idea that family identity takes precedence over individual identity. In the world of *familismo*, every action an individual takes reflects on the family, whether negative or positive. In this environment, it becomes problematic to see the benefits of knowing one's HIV status, resulting in a strong disincentive against testing.

Latino Risk Factors for HIV/AIDS: Barriers to Provision of Care

Myth of Singular Latino Community

Differences between groups of differing national origins.

Factors such as language, economic status and access to education vary from country to country. These differences may influence how different Latino groups access care and services. Recent studies have illuminated more subtle differences that could significantly impact efforts to provide services to Latino communities. Central Americans (i.e., Salvadorans), Dominicans, and South Americans (i.e., Columbians) are more likely to feel that society's moral values are better in their country of origin than larger groups with a longer history of immigration to the United States, such as Cubans, Mexicans, and Puerto Ricans.²¹ When asked if the strength of family ties were better in their country of origin or in the United States, Dominicans (72 percent) and Colombians (76 percent) were far more likely to feel they were better in their country of origin than were Mexicans (47 percent) or Puerto Ricans (48 percent). Salvadorans were far more likely to report having a problem communicating with health care providers because of language barriers (42 percent) than were Puerto Ricans (15 percent); Mexicans fell into the higher end of this scale, with 31 percent reporting difficulties due to language.²¹

Not just English or Spanish

A growing number of Latino immigrants, particularly in California, are indigenous people. Many of these indigenous people are not able to speak English or Spanish and primarily come from impoverished areas of Mexico where they experienced significant discrimination by the Spanish-speaking majority. This group comprises a growing percentage of the farm worker population.¹¹

Distribution beyond urban and rural areas

According to Suro and Singer, "Latinos have spread out faster than any previous immigrant or internal migration wave."⁵ Latinos within California have emerged as several geographically distinct populations: urban, suburban, rural, and border region. While these groups overlap (most notably in the San Diego region), each faces unique issues. When evaluating the relative distribution of programs throughout the state, LAB recommends that each geographical group be considered separately.

- **Urban:** San Francisco, San Diego, Fresno, Sacramento, and Los Angeles Counties. As a general rule, individuals living within these areas have an increased education level, have increased access to social services and health care, and are more likely to have some level of English proficiency.
- **Suburban:** The suburban counties surrounding the aforementioned urban areas contain a mix of migrants and well-established Latino families. In the experience of LAB members, a majority of suburban Latinos who live near an urban center work and live in the suburbs and are unlikely to utilize urban services.
- **Rural:** Including, but not limited to, agriculture-dominated counties in the Central Valley, Eastern Desert, along the coast, and in Northern and Southern California. Rural Latinos face significant barriers in access to any services and are more likely to be poor and have a lower level of education.

- **Border Region:** In San Diego and Imperial Counties along the border between California and Mexico many Latinos have work, family, and recreational activities on both sides of the border.

Fifty-four percent of all Latinos in the United States reside in the suburbs.⁵ In California, several cities have seen a higher rate of growth in their suburbs than in the cities. Sacramento's Latino population grew by 80 percent in the suburbs from 1990 to 2000, compared with 50 percent in the city center. San Francisco, which has a high concentration of services for Latinos within the city's urban center, saw that population grow by 40 percent in the suburbs, compared with just 13 percent in the center.

Latinos discriminating against other Latinos

In a national survey of Latinos from a variety of backgrounds, an overwhelming majority (83 percent) reported the problem of Latinos discriminating against other Latinos.²¹ Forty-one percent felt that this was a result of different levels of income and education. A smaller percentage (34 percent) felt that it was related to country of origin. This suggests that ensuring Latino clients have a Latino provider is not a complete measure of cultural competency. However, this finding should not discourage these efforts, as studies have shown that Latino patients do choose a Latino provider if given a choice.¹²

Lack of Trained, Linguistically-Competent Health Care Providers

Racial and ethnic disparities in health care can most easily and directly be linked to a failure to address language barriers and to assist communication between patient and provider. Several studies have examined the linkage between language and health care processes and outcomes. Unsurprisingly, having a language-concordant physician has been shown to be associated with better patient self-reported physical functioning, psychological well-being, health perceptions, and lower pain. Not fully understanding the provider was linked in one study to decreased understanding of the side effects of medication and decreased levels of satisfaction with medical care.¹² This study also found that in some situations, Spanish-speaking patients were more likely to take certain screening tests than their English-speaking Latino counterparts, leading the authors to speculate that testing served as a substitution for oral communication.¹²

Knowing the importance of linguistic access, and in an effort to become more culturally competent, many health care providers have worked hard to increase the number of linguistically trained staff and available interpreters. This effort is hampered by the increase in demand as a result of constant immigration, the generally overburdened state of services to low-income populations, and the general lack of education among the Latino population resulting in a smaller pool of Spanish speaking, medically-trained candidates. Having linguistically-skilled but racially-discordant providers is a necessary intermediate step for many health care institutions. In situations where this is not possible, it is common for providers to rely upon family or friends of the patient, or upon other translators who are not medically trained. Both situations are challenging. Relying upon persons known to the patient to translate may erode confidentiality and limit the patient's honesty when discussing potentially stigmatizing personal behaviors (e.g., sexuality, drug use) or diseases, namely HIV. Using translators who can speak the patient's language but who are not medically trained leaves open the possibility of increased confusion and the chance that questions, responses, treatments, tests, or medicines are not explained properly.

Culture of Medicine

Studies have demonstrated that interventions of a longer duration are more effective with the Latino community than short or single-session interventions.³⁷ “Longer duration” may be defined as either repeated sessions over a period of time, or simply more time allocated to a single session. Given the complex nature of issues that need to be addressed, and the *personalismo* integral to so much of the Latino culture, short or one-time interventions are often less effective when trying to affect individual behavior change. However, the need for longer or more sessions runs directly counter to the culture of medical environments, which are designed to serve a maximum number of individuals in a limited amount of time. This is particularly true in the age of managed care and in the stressed environments such as emergency rooms where many low-income Latinos access care for the first time. Medical practitioners are additionally trained to “filter out” the circumstances surrounding a patient’s life in order to hone in on a diagnosis.¹³ This is in direct conflict with relationship-based Latino culture and the spiritual components many Latinos associate with diseases. By ignoring these issues, the practitioner may be more efficient, but may also lose credibility and patient trust.

Fear of La Migra

In addition to basic income level, immigration status is correlated with limited access to public assistance and the likelihood of being part of the working poor. Even among those who have access to health care, utilization rates can be low when they fear anti-immigration sentiment or misunderstand immigration policy.

Fear of immigration authorities, frequently referred to as ‘*La Migra*,’ includes real concerns of incarceration and deportation for the undocumented and fears of harassment for legal Latino residents. A 2000 study of agricultural workers in California found that these fears are deep enough to keep immigrants indoors when not working, even preventing some from going to the grocery store.¹⁶

The implications of general “fear of *La Migra*” are multifold. Depression and isolation, already an issue among immigrant Latinos who are separated from family and friends, become more acute when Latinos avoid forging new relationships through fear or physical isolation. Agricultural workers, whose jobs require daily physical activity, report high rates of obesity and diabetes. This can be attributable to a lack of recreational activity, and to an increase in eating and substance use as a result of isolation. Additionally, fear of being identified as an undocumented immigrant and reported to immigration authorities keep many immigrants from seeking mainstream services such as medical and dental care, even when conditions become severe.¹⁶

Lack of Data

Funding levels are, of necessity, affected by available data. Having inadequate research data limits funds for the Latino community. Therefore, it becomes critically important to assess the epidemic’s impact on any community as accurately as possible.

Lack of data on rural/agricultural Latinos

In 1999, the California Institute for Rural Studies (CIRS) conducted a statewide survey of the health status of the state's agricultural workers. This study provided the first-ever baseline health status data for this population, despite the fact that it makes up one million people employed in a \$28 billion industry.¹⁶ CIRS was unable to complete the intended HIV seroprevalence tests as part of this survey. Estimated HIV infection rates among rural Latinos are currently not available.

There are several explanations for the lack of research on low-income rural and migrant populations. First, initial and follow-up data are far more difficult and expensive because this population does not maintain a consistent residence. Second, the lack of a home telephone leaves some people inaccessible for potential studies. Third, limited research funding forces groups such as CIRS to abandon activities that are not directly related to a targeted research question, but are ethically important to assess health status. Examples of this include HIV pre- and post-test counseling or provision of transportation for related medical testing or treatment based on their findings. Additional barriers within these Latino communities include the inability to speak either English or Spanish well, or to read in either language.

While the dearth of research on agricultural workers may not be a conscious oversight, it, nonetheless, has a significant impact on the accuracy of information about the Latino community, as a majority of these California's migrant workers are Latino.

“Hispanic” and race

It is nearly impossible to get an accurate count of how many residents in the United States have ethnic and/or cultural roots that originate in Latin America using current data collection methods. In an attempt to reflect the reality that “Hispanic” is a description of origin, and not a true racial designation, several key data collecting systems (including the U.S. Census) have designated *ethnicity* as “Hispanic/Non-Hispanic,” outside the category *race*. “Race” encompasses: White; Black, African American, or Negro; Indian (American), Eskimo, or Aleut; Asian or Pacific Islander. The majority of those who checked “Hispanic” in the 2000 U.S. Census were included under “White,” with the next highest category being “Black.”¹⁶

However, when asked in a national survey about this form of classification, Latinos clearly indicated that they did not see themselves fitting into any of these five racial categories. Nearly all (97 percent) of the U.S. Census respondents who chose “Some Other Race” were Latino.²⁰ Another survey of California's agricultural workers found similar results, with 91 percent of respondents selecting “other” rather than the five racial categories offered by the U.S. Census.

This dual way of collecting data is significant when tracking units of service at the individual service levels provider and when attempting to determine the relative needs of different communities. Additionally, because separation of “ethnicity” from “race” began on the U.S. Census in 1990, it is difficult to make accurate comparisons in data before and after the change. Many researchers are still comparing Latinos directly with other races, even when using U.S. Census data – in recognition that in reality Latinos are treated as a separate race, comparable to “White,” “Black,” etc., or to make it possible to make U.S. Census data comparisons pre- and post-1990.

Cultural competency

Organizations and individuals who work with Latinos and other minority populations strive to improve levels of cultural competency. One key effort has been to increase the number of Latinos on staff, yet in the health care arena it has been noted that “little evidence exists to directly demonstrate that the quality of care provided is better when minority patients and their providers are of the same race or ethnic group.”¹² Overall, LAB expressed the need to have “best practice” evaluations of cultural competency models currently in use throughout California.

Border region

The U.S.-Mexico border region encompasses the area of 100 kilometers (62 miles) on either side of the border.³⁸ The California-Mexico border is one of the busiest land-based transnational border crossings, with over 90 million crossings between Baja, California and California in 2001.³⁸ Many people who make these crossings travel back and forth across the border several times in one year or even in the same month. Due to this heavy traffic, the area is considered by many to be a singular epidemiological area for disease control and prevention, as well as for health promotion. High quality data on the residents of this region is scarce due to the: 1) difficulties of working with the health care monitoring systems of two different countries; 2) challenges in providing services for undocumented individuals at a time when border control is a national priority; and 3) difficulties in tracking a highly mobile population. In fact, a health study of the area used data on U.S. Latino populations as a proxy for Mexican Americans and people of Mexican origin in California because data on immigrants was scarce.³⁹

Section II: Latino Advisory Board Recommendations

The California Department of Public Health/Office of AIDS (CDPH/OA) Latino Advisory Board carefully reviewed HIV/AIDS epidemic trends, risk factors associated with Latino HIV/AIDS infection rates, as well as prevention, care and treatment concerns for HIV-infected Latinos. The review led to a series of recommendations. As earlier mentioned these recommendations include goals that are within the scope of California's public health system and those that extend to the national and international level. Again, the LAB recognizes California limitations in this regard, but would be remiss in not mentioning these larger recommendations, as they impact Latino HIV/AIDS prevention and care in California. The LAB will continue to work with CDPH/OA to unpack these recommendations to support the Latino community needs in HIV education, prevention, care and treatment.

Recommendations for State of California Department of Public Health, Office of AIDS Consideration

1. Revise categories of analysis and service provision to reflect significant socio-economic and cultural differences throughout California.
2. Develop Latino leadership to assure that Latinos of various backgrounds are integrated into HIV planning processes; develop community organizers for mobilization.
3. Develop and implement culturally and linguistically competent models for HIV prevention and care that identify socio-economic, geographic and cultural differences among Latinos throughout California.

Relevant for State, National, and International Partner Consideration

4. Support and expand local, national, and bi-national research to address HIV/AIDS in Latino communities.
5. Strengthen and expand international collaborations and partnerships.
6. Address homophobia, transphobia, stigma, and silence. Expand efforts to make HIV less stigmatized and promote accurate information about HIV and AIDS in Latino communities.

Relevant for National and International Partner Consideration

7. Improve access to prevention, care, and treatment services for Latinos in California regardless of their immigration, citizenship, or insurance status.
8. Assess the effectiveness of the American medical system on Latinos born outside the United States and differences in attitudes among Latinos towards health and health care.

Detailed Recommendations

Recommendations for State of California Department of Public Health, Office of AIDS Consideration

Recommendation #1

Revise categories of analysis and service provision to reflect significant socio-economic and cultural differences throughout California.

1.1 Design programs with a clear understanding of the distinctions between immigrant and non-immigrant Latinos, and between primarily English-, primarily Spanish-, and indigenous language-speaking populations. Service gap analysis should include these distinctions, as both the needs and potential strategies for each population differ greatly.

1.2 Design programs with a clear understanding of the distinctions between immigrants from different countries. Research has demonstrated that risk behaviors, cultural expectations, and socioeconomic status can vary greatly by country of origin.

1.3 Take into consideration that Latinos in different areas of California face notable differences in availability of services based both upon their geography and their own access to transportation. Geographically, Latinos in California can be divided into four generalized groupings: urban, suburban, rural, and border region. These groupings do not capture all Latinos in the state, but are still useful categories when considering available levels of service provision, identifying available support to service providers, and designing research and strategies for the future.

Recommendation #2

Develop Latino leadership to assure that Latinos of various backgrounds are integrated into HIV planning processes; develop community organizers for mobilization.

2.1 Provide technical assistance to HIV/AIDS programs throughout the state in developing and promoting Latino leadership.

2.2 Move beyond the concept of "community representatives" in recognition of the wide diversity within Latino communities. LAB recommends creating a system for identifying and recruiting Latino individuals from outside the HIV community to also participate in HIV-related discussions. Such individuals may have different insights into their own communities and may be able to provide valuable information for policy implementation from a relationship-driven perspective.

2.3 Identify and honor natural leaders in the Latino community both within the United States and abroad, and promote their contributions to the community, regardless of education level or language skills. Support these individuals through training and mentorship and actively involve them in decision-making.

2.4 Recognize the culture of *personalismo* and use a relationship-based approach in implementing new HIV/AIDS programs into Latino communities. Identify and develop leaders who may not be currently involved in HIV/AIDS, but who have insight into and relationships with the targeted communities.

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2.5 Utilize and expand upon trend data such as health care utilization, HIV testing, and population shifts, when determining current and future needs and gaps in services. Additionally, include Latinos on planning bodies to give insight into unrepresented communities.

2.6 Create a system of training and mentorship to support the transition from advocate to policymaker.

2.7 LAB recommends that churches be recognized for their roles as a source for community, information, and leadership and be integrated as a key resource for health information and identification of new Latino leaders.

2.8 Create a system that develops leadership skills among the recipients of HIV-related services. This system can include the development of consumer groups, speakers' bureaus, and other methods that build upon a patient's experience and knowledge.

Recommendation #3

Develop and implement culturally and linguistically competent models for HIV prevention and care that identify socio-economic, geographic and cultural differences among Latinos throughout California.

3.1 Fund training and other resources to enable organizations to meet federal standards for provision of culturally competent care at a minimum and to achieve cultural proficiency whenever possible. LAB feels strongly that current levels of cultural competency trainings are inadequate in most health care and HIV/AIDS service provision settings. Improving education to service providers at all levels can help to strengthen the relationships between providers and the communities they serve.

3.2 Inform California health care providers that Latinos statewide commonly seek treatments in Mexico and provider-client communication in this situation is important to ensure good health outcomes.

3.3 LAB feels strongly that CDPH/OA should lead the effort to develop California's own standards of "cultural competency."

Relevant for State, National, and International Partner Consideration

Recommendation #4

Support and expand local, national, and binational research to address HIV/AIDS in Latino communities

4.1 CDPH/OA should provide guidance to the research community to identify key areas of research gaps, develop strategies for reaching difficult populations (e.g., migrants), and forge collaborations between researchers and community members.

4.2 LAB feels strongly that a community-driven research advisory group specific to Latino HIV/AIDS should be created, and welcomes CDPH/OA's support and leading role in this effort.

4.3 Expand CDPH/OA's current role as "information clearinghouse" to include information on current research efforts in California, Mexico, and other Latin (Central and South) American countries, whether funded by CDPH/OA or not. Serve as potential linkage

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between community members and researchers, with a goal of increasing collaboration. Conduct periodic reviews of current research to ensure parity and relevance of research regarding current trends in HIV infection and AIDS diagnoses.

4.4 Promote research to evaluate prevention, treatment and care activities of Latino service organizations to ensure successful interventions and identify best practices.

4.5 Support new research on Latino populations in California that are experiencing increasing rates of HIV infection. Of primary concern to LAB are understanding the needs of and identifying strategies for Latino youth, substance users, women, Transgender and suburban residents.

4.6 Support research that examines health outcomes among Latinos following implementation of cultural competency programs.

4.7 Increase awareness of existing research results by reporting back to the community in a reading/comprehension level appropriate to the community studied, and translating findings in English journals into (at a minimum) Spanish, and Spanish-language journals into English.

4.8 Recognize and address the cultural conflict between the “immediate solution” system of medical care in many Latinos’ country of origin and the longer-term approach taken in current HIV treatments.

4.9 Expand formative research in many areas of the Latino community to identify new areas for program development and funding needs.

4.10 Include local community providers at the earliest stages of research planning, and train and use community members as research project staff.

Recommendation #5

Strengthen and expand international collaborations and partnerships.

5.1 LAB applauds CDPH/OA’s efforts to address issues in the U.S.-Mexico border region such as projects with the U.S.-Mexico Binational Migrant Committee, La Iniciativa de Salud Fronteriza, ISESALUD, CENSIDA, and other binational and Mexican public health organizations. LAB recommends continuing these efforts, as well as using existing relationships to expand both services and opportunities for research. CDPH/OA can lead the efforts to create a system for tracking the rate of client access to, and the success of treatments for, services on both sides of the border (particularly for chronic conditions such as HIV, tuberculosis, and diabetes). Such a system is essential for monitoring health outcomes; however, it must be able to track clients regardless of immigration status.

5.2 In collaboration with Mexican health care providers, provide and evaluate HIV/AIDS services to ensure a continuum of quality care for Latinos who seek services on both sides of the border between Mexico and California.

5.3 Develop a resource guide for providers on both sides of the border, particularly those working with populations who seek HIV/AIDS services in California and Mexico. LAB recommends that CDPH/OA take the lead in assembling and publishing this resource guide in hard copy and on the Internet.

5.4 Create social marketing and other information campaigns that address the fears of deportation some undocumented immigrants have regarding care services. LAB feels that

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making binational collaborations highly public can be an important part of reducing these fears.

5.5 Create collaborations beyond HIV and toward a model of holistic health, integrating HIV services into a wider health care model. For example, given the high incidence of tuberculosis in this region, particularly among those born in Mexico,⁴¹ and the known association between development of tuberculosis disease and HIV seroprevalence, it is critical that any efforts to address tuberculosis include HIV prevention and treatment services.

Recommendation #6

Address homophobia, transphobia, stigma, and silence. Expand efforts to make HIV less stigmatized and promote accurate information about HIV and AIDS in Latino communities.

6.1 Educate journalists and editors in all forms of media on the culture and issues of the Latino communities.

6.2 Provide HIV training within Latino community media outlets to reduce stigma and promote accurate information.

6.3 Support efforts to provide HIV-related education to Latino populations through less conventional or mainstream forms of media such as *tetra compassion* (theatre with roots in the Mexican farm worker communities), speakers' bureaus, and radio.

6.4 Enable providers and clients in Latino HIV service agencies to have their own voice in the media. Provide trainings on public speaking, speaking on camera, and developing media messages aimed at reducing HIV stigma and promoting HIV education.

Relevant for National and International Partner Consideration

Recommendation #7

Improve access to prevention, care, and treatment services for Latinos in California regardless of their immigration, citizenship, or insurance status.

7.1 Support efforts to expand access to prescription drugs for the uninsured and protect health care for all California residents.

7.2 Design binational collaborations to protect the health of Latinos regardless of immigration or citizenship status, while ensuring access to quality health care.

7.3 Ensure ADAP and other Ryan White Comprehensive AIDS Resources Emergency Act programs are continuously funded and expanded to reach underserved Latino populations.

7.4 Take steps to ensure that immigrants understand the impact that immigration status has on their ability to access health services. Create public information campaigns at all locations where immigrants may access health services, information, or supplies.

Recommendation #8

Assess the effectiveness of the American medical system on Latinos born outside the United States and differences in attitudes among Latinos towards health and health care

8.1 Support the development and implementation of health care delivery systems that reflect key Latino cultural values such as *personalismo* and *familismo*. Innovative models that are built upon existing community networks and include these cultural values as a foundation have been found by LAB to be among the most successful in addressing entrenched health care issues. Among these models are systems that provide long-term, relationship-based services, such as CDPH/OA's Bridge Project and the *promotora* model. Increasing the availability of child- and family-friendly services is another goal of LAB. Ensure that the patient's family is not involved in potentially stigmatizing conversations, and that patients feel able to get the answers they need, by securing the availability of adequately trained medical translators.

8.2 Work to improve the availability and scope of holistic health services. LAB recommends the inclusion of HIV testing in other primary health services in an effort to increase rates of Latinos who are HIV positive in care. Placing HIV testing into a larger health context can improve compliance, identify HIV-positive individuals at earlier stages of infection, and reduce the overall risk of disease transmission.

8.3 Offer trainings to providers on Latino culture and culturally tailored information to Latinos about the health care environment in California. It is important that Latinos understand not only what their rights are as patients, but also what to expect. Assumptions of paperwork, the potentially undetectable impact of taking needed treatments, delays in treatment during analysis of one's condition, the sense of control over one's health, and the chronic nature of certain diseases may all be foreign to an immigrant Latino. Patients who are more prepared for the medical culture may be better able to find ways to work within it, thus improving the overall experience for both provider and patient.

8.4 Work to integrate continuous services in rural communities by funding mobile van-type interventions. The mobile van is an essential and effective method of providing primary care and short-term treatments in rural areas. If integrated into a larger system of care, the mobile van intervention can provide access to ongoing monitoring and treatment for chronic conditions, and be an important gateway to consistent health care. Another key to the success of the mobile van model in Latino communities would be regular staff who can work to build relationships and trust.

8.5 Strongly encourage those who intend to work in any field relating to the health care of immigrant populations to spend time working in the home countries of their clients. Such experience will increase cultural awareness so that these clients may receive optimal health care.

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