



**SHAPING
THE NEW
RESPONSE:
HIV/AIDS
& LATINOS
IN
THE
DEEP
SOUTH**



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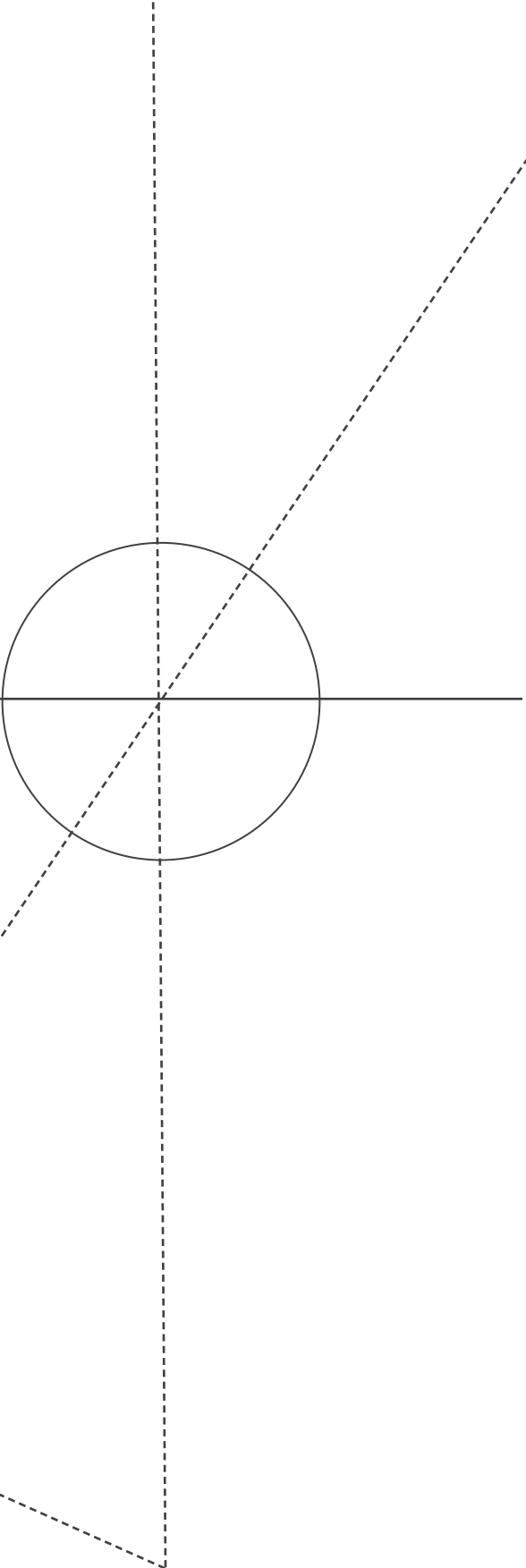
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**SHAPING
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THE “DEEP SOUTH PROJECT” INVESTIGATED
CURRENT HEALTH CONDITIONS IN THE STATES OF
NORTH CAROLINA, SOUTH CAROLINA, GEORGIA,
ALABAMA, MISSISSIPPI, TENNESSEE AND LOUISIANA.



EXECUTIVE SUMMARY

A two-year fact-finding and cooperation program led by the Latino Commission on AIDS in seven southern states found evidence that Latinos are being infected with HIV at disproportionate rates and that the trend is accelerating. Although new diagnoses among African-Americans are the highest in the South, Latino rates are substantially greater than non-Latino Whites while prevention messages and educational programs only sporadically reach them.

Some 2 million Latino residents of the seven states covered by the Commission's "Deep South Project" face severe limitations in their access to health care of any sort, a major obstacle to HIV/AIDS prevention and care efforts. While immigrants encounter discrimination in daily life, states too often are stepping up restrictions designed to exclude them from government services instead of incorporating new Latino communities into public health-promotion efforts and addressing their specific needs and vulnerabilities.

Existing AIDS prevention organizations and health departments are constrained by a severe shortage of

bilingual and bicultural health professionals in the region. Despite the rise of HIV infection among Latino residents in the South, many individuals do not discover their HIV-positive status until they are too sick to benefit fully from available treatments.

The main findings of the two-year investigation were:

- Throughout the region HIV infection and AIDS cases are rising at an alarming rate among Latino populations while prevention education lags behind. Access to HIV-related medical care is complicated by fear, stigma and, for the undocumented, a variety of administrative, practical and legal obstacles.
- Latinos often discover they are HIV-positive only at a late stage of infection as a result of serious illness or through pre-natal screening. In many communities pregnancy-related care is the main avenue for detecting cases of HIV among Latinos, including men.
- Many Latinos in the South, especially recent immigrants, do not have access to health care and are not reached by health promotion activities.



- AIDS prevention and service organizations throughout the region are making efforts to establish contact with Latino communities even without Spanish-speaking employees.
- The high level of transience among the Latino and immigrant communities complicates attempts to carry out traditional HIV prevention initiatives based on peer-to-peer education.
- The increasing visibility of anti-immigrant sentiment makes Latinos distrustful of health departments and medical providers, which weakens campaigns to promote public health.
- Medical care for those infected with HIV is often available; however, undocumented clients have additional burdens in managing the disease.
- The lack of trained bilingual professional staff inhibits prevention initiatives and delivery of care; the few bilingual workers now in the field are overstretched and expected to fulfill too many roles.
- A well-organized and -marketed commercial sex industry generates a risk environment both for immigrant men and for the sex workers providing the services.
- High birth rates among Latinos has led to a massive increase in Spanish-speaking public school enrollment, which makes more urgent the need for appropriate educational programs for parents and for Latino adolescents in the region.
- Interventions targeting gay Latinos or other Latino men who have sex with men are rare in the South.

These general highlights are discussed in detail in the following section. After a state-by-state summary of current conditions, recommendations for action that emerged from the seven statewide meetings are presented followed by the Commission's own recommendations.

LATINOS OFTEN DISCOVER THEY ARE
HIV-POSITIVE ONLY AT A LATE STAGE OF
INFECTION AS A RESULT OF SERIOUS ILLNESS
OR THROUGH PRE-NATAL SCREENING.



A blurred photograph of a person running on a field with autumn trees in the background. The person is on the left side of the frame, wearing a dark shirt and light-colored pants. The background consists of a dense line of trees with autumn foliage in shades of orange, yellow, and green. The foreground is a light-colored, possibly sandy or grassy field. The overall image is out of focus, creating a sense of motion and depth.

INCREASING VISIBILITY OF ANTI-IMMIGRANT SENTIMENT MAKES LATINOS

DISTRUSTFUL OF HEALTH DEPARTMENTS AND MEDICAL PROVIDERS.



A photograph of a mobile home park during autumn. The scene features several white mobile homes with dark roofs and trim. In the foreground, there are several black trash bins. The ground is covered with fallen brown leaves. Large trees with vibrant yellow and orange foliage are in the background. The text of the states is overlaid in white, bold, sans-serif font across the center of the image.

NORTH CAROLINA

SOUTH CAROLINA

GEORGIA

ALABAMA

MISSISSIPPI

TENNESSEE

LOUISIANA



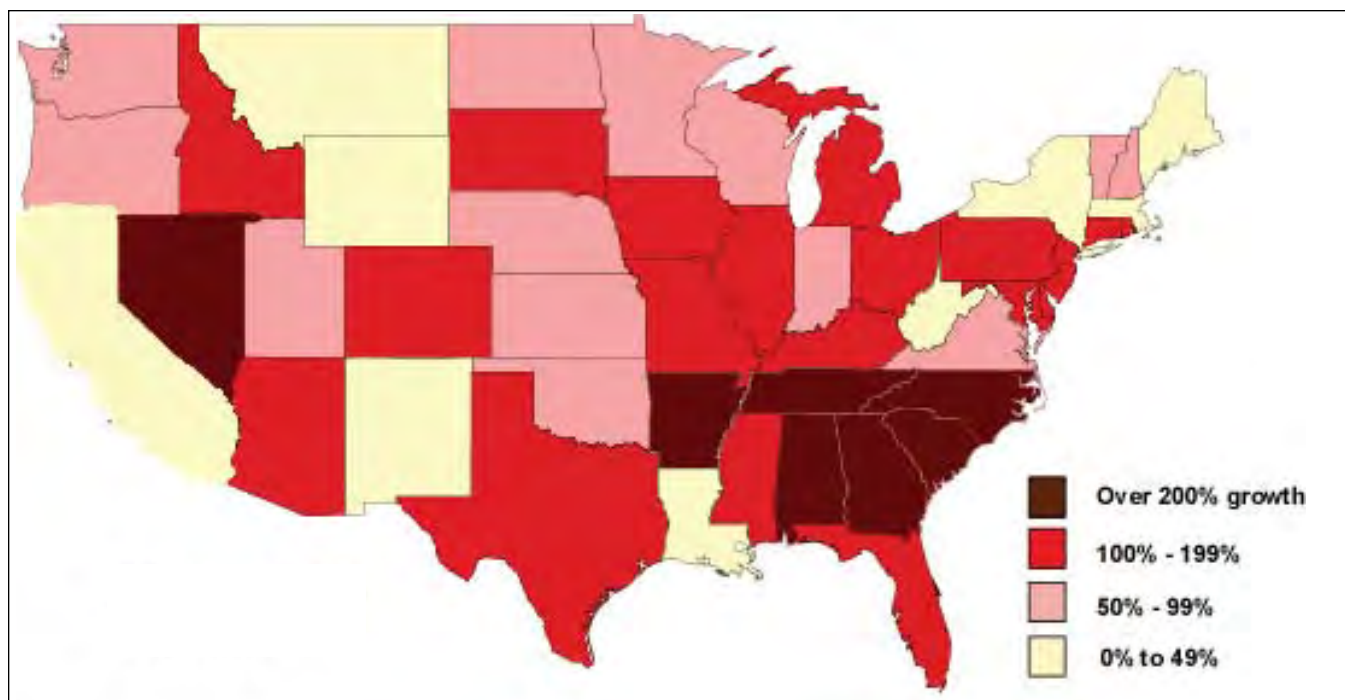
WHY DEEP SOUTH IMMIGRANT COMMUNITIES?

Like all persons, immigrants in the emerging Latino communities of the South are at risk of acquiring HIV. But they also face additional challenges in remaining free of the virus during the years they spend in the United States and in obtaining the necessary care if they do receive an HIV diagnosis. AIDS service organizations (ASOs) and other groups are searching for ways to reduce the numbers of people struggling with the rigors of an HIV diagnosis and AIDS in the midst of many other hardships.

The focus on the Deep South arose from several factors: the new attention paid to the historical shortcomings of social services in the region after the devastation of the 2005 hurricanes as well as the evidence that the South has become a significant new epicenter for the HIV/AIDS epidemic.

In addition, the influx of Latinos to many southeastern states was extremely rapid. Some southern counties registered a 10- or 15-fold increase in Spanish-speaking residents

Figure 1: **Percentage Growth of Latino Population by State***



Source: U.S. Census, 2000

(*) Map reflects Latino population growth from 1990 to 2000. Many Latinos in Louisiana were known to arrive after Hurricane Katrina.



in a single decade while providers there often had little or no previous experience with Latinos. Local health departments could not count on seasoned service organizations such as those found in the older Latino communities of California, New York, Florida or the Southwest to respond to the needs of the new populations. As a result, Latinos were soon affected by rising rates of HIV infection.

In the course of the Deep South Project, since its inception in 2006, certain recurrent themes have surfaced, an indication that communities all over the South face many common challenges. The recommendations for action that emerged from the seven statewide roundtables and individual interviews also bore significant similarities. Efforts undertaken now to create or adapt prevention and care strategies that address the unique conditions faced by these populations will provide valuable lessons for providers and advocates all over the South.

Given the gradual but inevitable integration of Latino immigrants and their children into southern society, policymakers including state and local health departments and state legislators must act prudently but decisively to protect the public's health by incorporating these populations into HIV/AIDS strategies and programs for both prevention and care. The nationwide, government-led effort to increase HIV testing and awareness and to incorporate HIV-positive individuals into the care system

as quickly as possible will flounder if any sectors of the population are excluded due to a short-sighted reluctance to extend benefits based on immigration status.

If temporary political pressures derail coherent public health strategies by blocking access to prevention education or necessary clinical care, states and localities eventually will pay the price with additional infections and poorer health outcomes for all populations. This report is an attempt to contribute to the formulation of sound public policies in this arena based on the accumulated experience and lessons learned in the U.S. and worldwide in over 30 years of efforts to combat the HIV/AIDS epidemic.



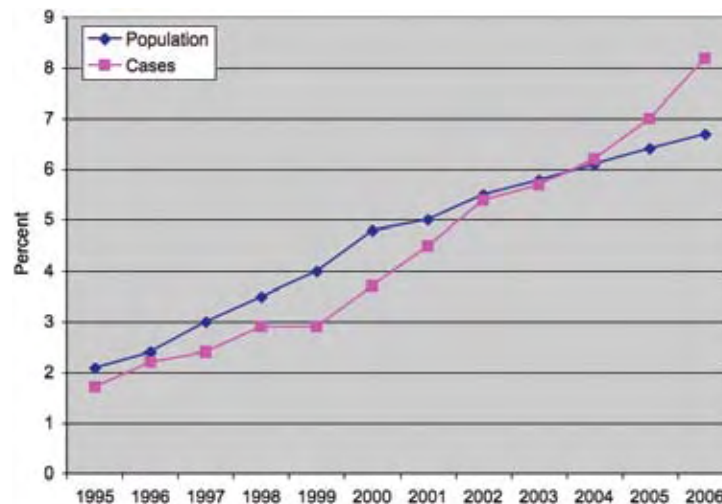
(1) HIV INFECTION AMONG LATINOS IN THE SOUTHEASTERN UNITED STATES IS ON THE RISE BOTH IN ABSOLUTE AND RELATIVE TERMS.

Estimated rates of new HIV infections among Latinos are consistently higher than those for Caucasians while lower than those of African-Americans in these states. Latinos now comprise a percentage of new HIV infections equivalent to or surpassing their estimated proportion of the population in the region. Nearly 9 percent of new HIV infections in North Carolina in 2007 were

found among Latino residents. The figures for the region have risen steadily from year to year even though infrequent HIV screening among Latinos may mask an even larger hidden epidemic among this population.

An adequate and timely response is inhibited by the tendency of federal and state health authorities to base priorities on current epidemiological data, which in any case usually lags as much as two years behind. Early detection of HIV infection, which is essential for both care and prevention goals, is made difficult by the immigrants' lack of regular connection to health services and the resulting tendency to avoid medical consultations except in emergencies.

Figure 2: North Carolina Latino population and proportion of total reported HIV cases.



Source: Felizzola J & Jones B (2008) 'The HIV/AIDS Epidemic in the NC Latino Community.' North Carolina Latino HIV/AIDS Forum, Jan 23, 2008, Raleigh.



(2) LATINOS SEEK CLINICAL CARE AT A LATE STAGE OF HIV INFECTION AND ARE OFTEN SERIOUSLY ILL WHEN DIAGNOSED.

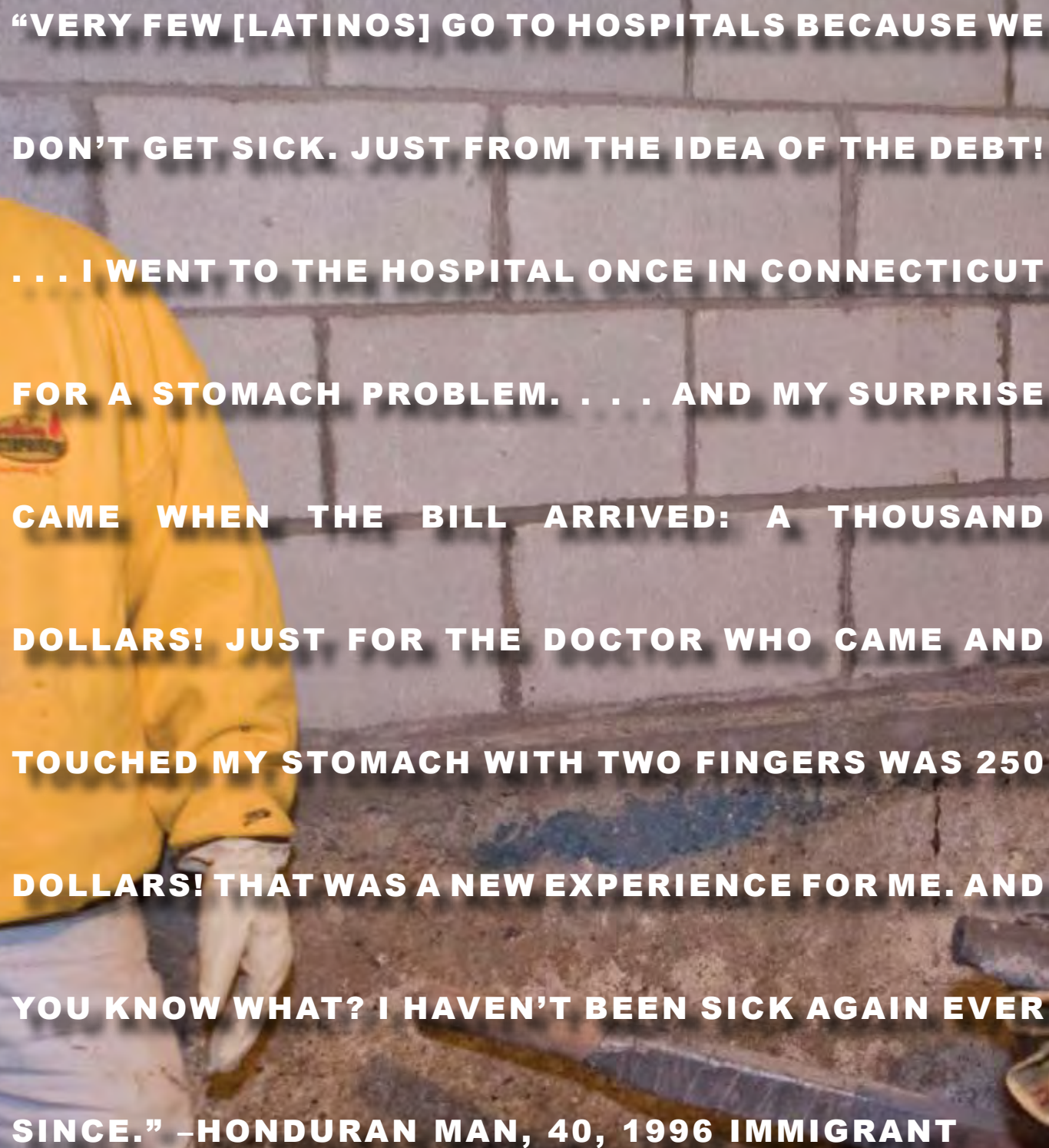
Many HIV cases among Latinos in the South are not discovered until the individual has fallen seriously ill, and so concurrent diagnoses of HIV and AIDS are common. Late testing translates into a poorer response to treatment, shorter life spans and a heavier burden on the care system. Although late testing is a problem for all races and ethnicities, the chances of early detection of an HIV infection among Latino residents are weakened by their tenuous links with primary care providers as well as the lack of routine HIV testing in the health facilities that they do use.

Latino newcomers often do not have health insurance and thus lack a main health provider¹. Use of emergency rooms for urgent care is common; at the same time, a South Carolina study found consistently missed opportunities for HIV screening in hospital emergency rooms². The only consistent HIV screening among Latinos occurs in the context of prenatal care—including for men, who are tested with their female partners.

(3) LATINO IMMIGRANTS FREQUENTLY ARE UNABLE TO ACCESS MEDICAL CARE OF ANY SORT, EVEN FOR SERIOUS ILLNESSES AND INJURIES. INCREASED STATE AND LOCAL RESTRICTIONS ON SERVICES TO NON-RESIDENTS PUSH IMMIGRANTS FURTHER AWAY FROM THE HEALTH SYSTEM. VOLUNTARY AND SAFETY-NET SERVICES ONLY PARTIALLY FILL THE GAP.

Only about half (51%) of Latinos who have lived in the United States for less than five years have a regular health care provider, compared with 79 percent of those who have been here for 15 years or more³. Although the overall good health of the youthful immigrant population is a contributing factor, separation from the healthcare system complicates preventive care and eventually will lead to poorer health outcomes and sharply increased use of curative care later in life.⁴

1. Livingston G, Minushkin S & Cohn D/Pew Hispanic Center, 'Hispanics and Health Care in the United States: Access, Information and Knowledge.' 13 Aug 2008. <http://pewhispanic.org/reports/report.php?ReportID=91> <<http://www.pewhispanic.org/>>
2. Duffus WA, 'Latinos in South Carolina and HIV/AIDS,' Roundtable presentation June 4, 2008.
3. Pew Hispanic Center, 2008.
4. Markides & Eschbach J (2005) 'Aging, Migration, and Mortality: Current Status of Research on the Hispanic Paradox.' *Gerontol B Psychol Sci Soc Sci* 60: S68-S75.



**“VERY FEW [LATINOS] GO TO HOSPITALS BECAUSE WE
DON’T GET SICK. JUST FROM THE IDEA OF THE DEBT!
. . . I WENT TO THE HOSPITAL ONCE IN CONNECTICUT
FOR A STOMACH PROBLEM. . . AND MY SURPRISE
CAME WHEN THE BILL ARRIVED: A THOUSAND
DOLLARS! JUST FOR THE DOCTOR WHO CAME AND
TOUCHED MY STOMACH WITH TWO FINGERS WAS 250
DOLLARS! THAT WAS A NEW EXPERIENCE FOR ME. AND
YOU KNOW WHAT? I HAVEN’T BEEN SICK AGAIN EVER
SINCE.” –HONDURAN MAN, 40, 1996 IMMIGRANT**



Some federally-funded community health centers, county or municipal prenatal clinics and other primary care facilities receive Latino clients, including the undocumented. However, access to specialist or secondary care and medication is often impossible for these residents. On-the-job injuries and ailments are common among workers employed for short periods or ‘off the books,’ and employers often avoid assuming health-related responsibilities for them. In a New Orleans study conducted after Hurricane Katrina, only 9 percent of undocumented Latino workers were found to have medical insurance, and only 38 percent received medications when needed.⁵

As the immigrant population is relatively youthful,⁶ the consequences of poor access to health services are not yet fully manifest. When individuals have no regular health providers, they ignore symptoms that should be treated promptly, avoid medical services except in extreme situations, and are not exposed to preventive counseling or offered important referrals for issues such as domestic violence or substance abuse. And they are less likely to engage in a discussion about the need for health-seeking behavior, all of which undermine HIV/AIDS prevention and care efforts.

The lack of primary care for an increasingly large pool of uninsured residents has stimulated some innovative initiatives for safety-net alternatives especially when the last-resort use of emergency rooms burdens local hospitals. For example, the LATCH program (Local Access to Coordinated Health Care) is a Duke University Medical Center effort involving outreach, primary care and case management to serve patients in clinical settings and in their homes using community health workers. LATCH, funded by the U.S. Bureau of Primary Health Care, includes a consortium to provide the services and to advocate for improved access. Outreach partners include CBOs, regional hospitals, city and county governments, and church-based social services.

Many of those involved in both primary care and HIV-related services recommend linking HIV prevention and care efforts with the broader demand for health care access. As an employee of an emergency health project for immigrants in New Orleans commented: “We are seeing men who have nowhere to go when they are injured on the job or when they have a serious illness. How do you discuss preventing a disease in the future with them when they can’t go to a doctor today?”⁷

5. Fussell E (2006) ‘Latino Immigrants in post-Katrina New Orleans.’ Regional Seminar on Labor Rights, New Orleans, Oct 19-22, 2006.
6. Jolly EJ (2004) “Beneath the Surface.” MOSAIC reports <http://main.edu.org/mosaic/Mosaic9/beneath.asp>
7. Gina Lutz, personal communication, May 2007.



(4) HIV PREVENTION SERVICES FOR LATINO POPULATIONS IN THE REGION ARE LACKING. FEW INTERVENTIONS ARE DESIGNED TO ADDRESS THE VULNERABILITIES FACING SINGLE MALES WHO OFTEN COMPRISE THE MAJORITY OF NEW ARRIVALS.

Many traditional HIV prevention strategies utilize peer educators, community leaders or workshop formats. But highly transient immigrant populations may have few established leaders, and their typically lengthy workdays make participation in most programs impossible. Educational approaches based on organized activities or the recruitment of key community gatekeepers to disseminate

HIV prevention messages through their everyday contacts are especially challenging under these conditions.

Existing social service agencies serving Latino and immigrant populations are rarely capable of taking on more systematic HIV education as they are overwhelmed by their clients' urgent survival issues. As a result, many prevention interventions focus heavily on encouraging Latinos to be tested for HIV. While these campaigns sometimes provide some education and may include pre- and post-test counseling, others are limited to screening for the disease and the incorporation of HIV-positive individuals into care.

Few interventions target men despite the heavily skewed male-female ratio among adult Latinos in the southern states (see Table 1).

Table 1: Male/female ratios of all Latino residentes of selected states, 2005

(in thousand)	Total Pop 2005	Latino Pop 2005	% of Total	M:F ratio
Alabama	4,443	99	2.20%	1.22:1
Georgia	8,821	625	7.09%	1.37:1
Louisiana	4,390	123	2.80%	1.08:1
Mississippi	2,824	*48	1.70%	1.74:1
N Carolina	8,411	533	6.37%	1.39:1
S Carolina	4,114	135	3.28%	1.37:1
Tennessee	5,811	173	2.98%	1.37:1
Total	38,814	1,736	4.47%	

U.S. Census Bureau 2005 American Community Survey <http://factfinder.census.gov/servlet>

*No estimate is given by the Census Bureau for Mississippi due to low cell size. The estimate shown is based on data from the Pew Hispanic Center.



“THE SITUATION WITH MIGRANTS IS SIMILAR TO THAT OF TEENAGERS—DENIAL OF RISK, RISK-TAKING, SELF-DETERMINATION. MIGRANTS ARE PEOPLE WHO BELIEVE THEY ARE NOT GOING TO DIE CROSSING THE BORDER, AND IF THEY MADE IT HERE, THEY WERE RIGHT! THAT EXPERIENCE IS RELEVANT TO THE OUTLOOK OF THE POPULATION WE ARE DEALING WITH.” –DR. EMILIO PARRADO, DUKE UNIVERSITY



As a result, long-term health concerns such as those represented by HIV/AIDS remain remote from the perspective of many Latino immigrants. The immigrants, who often arrive with minimum contacts and large debts to pay off while the threat of deportation looms and put in long work days with little time off. Leisure activities may involve drinking or drug consumption as well as soccer games and church attendance. Housing tends to be overcrowded and unstable with constant changes in the occupants of a given apartment or neighborhood. Even testing campaigns that entail follow-up visits to deliver results can be undermined by the high degree of transience of the population. Approaches relying on modifying social norms or utilizing peer educators to reach social networks face significant obstacles under these circumstances.

(5) PREVENTION EFFORTS TARGETED TO GAY AND OTHER HOMOSEXUALLY-ACTIVE LATINO MEN ARE UNCOMMON DESPITE THEIR SIGNIFICANT NUMBERS IN HIV INFECTION STATISTICS.

Male-to-male transmission often accounts for approximately half of new infections among Latino men. For example, 61 percent of all Latino male cases of HIV infection in North Carolina were attributed to this factor.⁸ However, only one program focusing on gay-identified or other men who have sex with men was active in the seven-state region during 2007.

8. Felizzolla J (2008) 'North Carolina Latino HIV/AIDS Initiative: A Statewide Response to an Increasing Epidemiological Trend of HIV Disease Cases among Latinos.' (PowerPoint) North Carolina DHSS Communicable Disease accessed at: www.latinoaids.org/programs/southproject/docs



(6) A WELL-ORGANIZED AND -MARKETED COMMERCIAL SEX INDUSTRY CREATES A RISK ENVIRONMENT BOTH FOR IMMIGRANT MEN AND FOR THE SEX WORKERS PROVIDING THE SERVICE.

Contact with sex workers is often the biggest change in the lives of young Mexican male immigrants, many of whom have little sexual experience upon reaching the United States as the age of sexual initiation is higher among Mexicans in Mexico. Three times as many Mexican immigrants in a North Carolina study⁹ reported that their sexual initiation in the United States occurred with a sex worker as compared to similar men in Mexico (21.4% v/s 7.6%). An Alan Guttmacher Institute study found that 28 percent of immigrant men surveyed in the U.S. had used commercial sex services during the past year compared to only 5 percent in Mexico.¹⁰

Immigrant men are systematically targeted to buy sex, often with aggressive marketing techniques. These services include: bordellos, door-to-door solicitations in Latino apartment complexes, façade businesses fronting for prostitution, topless bars and call-girl operations with ‘sectors’ controlled by established operators. Although

some educational interventions have occurred, few lessons have been shared on this work in the region.

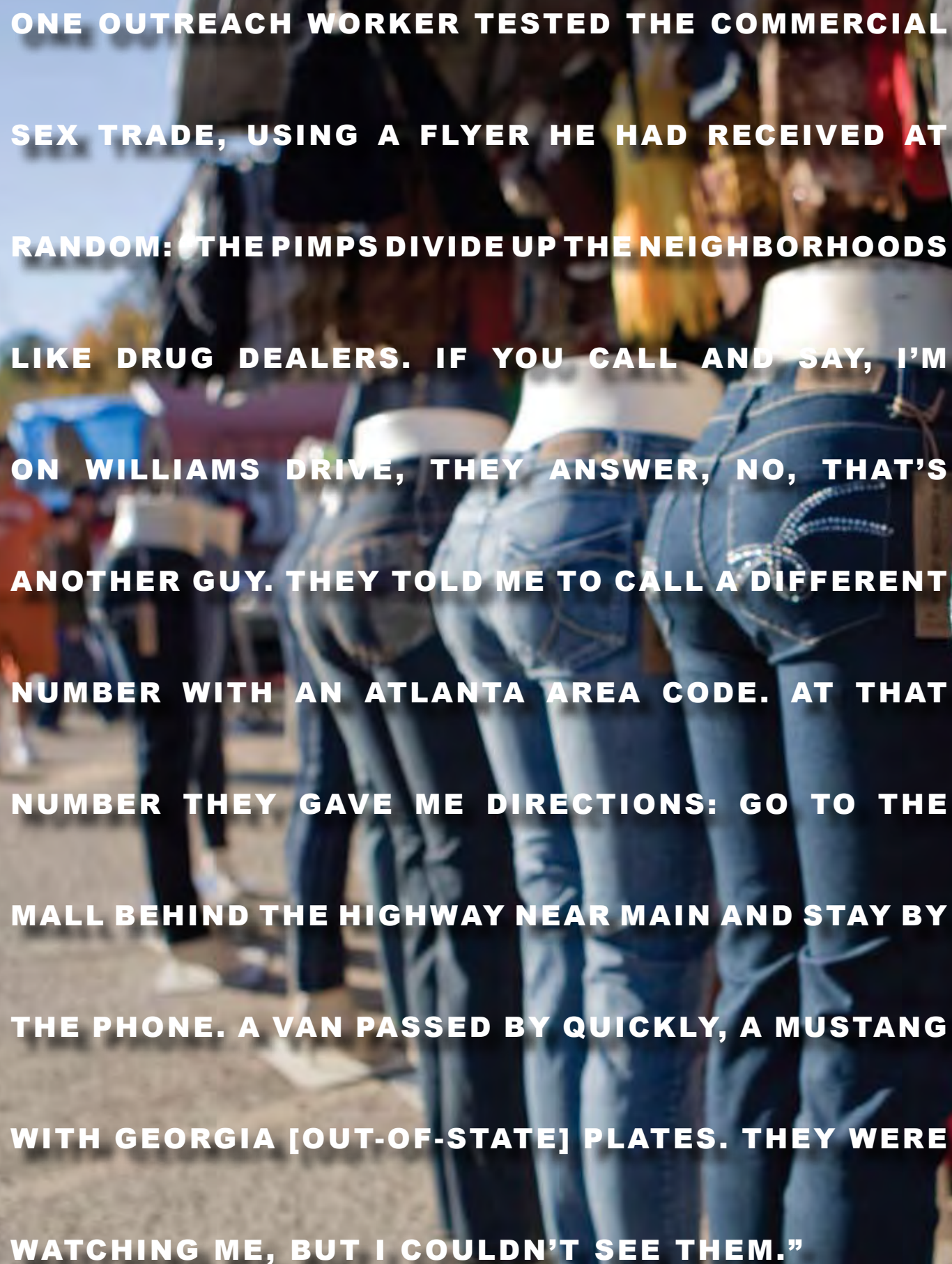
(7) THE INCREASING VISIBILITY OF ANTI-IMMIGRANT SENTIMENT UNDERMINES LATINO RESIDENTS’ HEALTH, AGGRAVATES THEIR DISTRUST OF HEALTH DEPARTMENTS AND FACILITIES AND WEAKENS CAMPAIGNS THAT RELY ON CONFIDENCE AND COMMUNICATION BETWEEN GOVERNMENT AND THE POPULACE.

One out of every eleven Americans of Hispanic ethnicity—regardless of immigration status—is stopped annually by a police agent and asked to prove his or her legal residence in the U.S.¹¹ The passage of anti-immigrant laws, denunciations of undocumented workers in news media and other open expressions of hostility push Latino residents further into clandestine lives and away from regular contact with healthcare institutions and public health services.

9. Parrado EA, McQuiston C & Flippen CA (2005) ‘Integrating Community Collaboration and Quantitative Methods for the Study of Gender and HIV Risks among Hispanic Migrants.’ *Social Methods Res* 24(2): 204-38.

10. The Alan Guttmacher Institute (2004) ‘Use of commercial sex workers among Hispanic migrants in North Carolina: Implications for the spread of HIV.’ *Perspect Sex Reprod Health* 36(4): 150-7.

11. Lopez MH & Minushkin S/Pew Hispanic Center (2008) ‘2008 National Survey of Latinos: Hispanics See Their Situation in U.S. Deteriorating; Oppose Key Immigration Enforcement Measures.’ www.pewhispanic.org/reports <<http://www.pewhispanic.org/reports>>



**ONE OUTREACH WORKER TESTED THE COMMERCIAL
SEX TRADE, USING A FLYER HE HAD RECEIVED AT
RANDOM: "THE PIMPS DIVIDE UP THE NEIGHBORHOODS
LIKE DRUG DEALERS. IF YOU CALL AND SAY, I'M
ON WILLIAMS DRIVE, THEY ANSWER, NO, THAT'S
ANOTHER GUY. THEY TOLD ME TO CALL A DIFFERENT
NUMBER WITH AN ATLANTA AREA CODE. AT THAT
NUMBER THEY GAVE ME DIRECTIONS: GO TO THE
MALL BEHIND THE HIGHWAY NEAR MAIN AND STAY BY
THE PHONE. A VAN PASSED BY QUICKLY, A MUSTANG
WITH GEORGIA [OUT-OF-STATE] PLATES. THEY WERE
WATCHING ME, BUT I COULDN'T SEE THEM."**



Routine traffic stops and minor arrests are increasingly used as occasions to review an individual's immigration status and detain the undocumented. Persistent reports suggest racial profiling in roadblocks throughout the South.

Immigrants also face assault or home invasions because they are known as 'walking banks' since most do not have accounts and will not report crimes to police; domestic violence victims are equally constrained from seeking relief. A daily existence characterized by fear of the authorities, victimization and frequent experiences of resentment and discrimination all undermine immigrants' well-being.

Fear of immigration raids or unwanted police attention also inhibits attendance at health fairs organized to attract Latino residents, which have been a popular strategy for disseminating information and referrals.

(8) THE SCARCITY OF BILINGUAL PROFESSIONALS IN THE HEALTH AND SERVICE PROFESSIONS HANDICAPS AGENCIES ABILITY TO SERVE SPANISH-SPEAKING CLIENTS.

The shortage of trained bilingual/ bicultural staff or collaborators blocks efforts to establish dynamic prevention education programs and to provide quality care to

HIV-positive Latino clients. Many bilingual professionals are transplants to the region from other states while the formation of professionals drawn directly from the affected communities is made difficult by the immigrants' low level of educational preparation and increasing restrictions on educational opportunities for undocumented minors and young adults. For example, foreign-born, non-naturalized children must now pay out-of-state rates at local colleges in several states, and graduates without legal residency papers will not be certified in some professions regardless of how many years they have resided in this country. Most U.S.-born children of these recent Latino immigrants are still 10 to 15 years away from even contemplating a career in the allied health professions.

Often, Latino professionals who do live in the area are unable to work in their areas of training because educational credentials from non-U.S. universities are not recognized.

When bilingual staff positions are added, these employees often are compelled to respond to a multitude of unmet needs among Latino clients, regardless of their original terms of employment. These may include attending clients, spearheading prevention work and providing medical interpretation for Spanish-speaking clients who may live in widely scattered localities within an agency's catchment area. These demands limit bilingual employees' flexibility in setting their own work priorities.

THERE IS A LIMITED NUMBER OF BILINGUAL
PROFESSIONALS TO SERVE THE INCREASING
HEALTH NEEDS OF THE LATINO POPULATION.





MEXICANS ARE THE MOST NUMEROUS AMONG THE IMMIGRANTS, BUT THERE ARE ALSO MANY HONDURANS, COLOMBIANS, VENEZUELAN, AND ECUADORIANS. GUATEMALANS, WHOSE FIRST LANGUAGE MAY NOT BE SPANISH, PREDOMINATE IN OTHER ZONES AND ARE OFTEN EMPLOYED IN THE POULTRY INDUSTRY.



ALABAMA

Table 2: **Demographic and epidemiological facts:**

Estimated 2007 state population (ACS):	4,628,000
Estimated 2007 Latino population (ACS)	25,000 (2.70%)
Reported cumulative HIV/AIDS cases 6/30/08	15,683*

* Lani Thompson, Alabama Department of Public Health, personal communication 11/6/2008.

Table 3: **Alabama reported overall and Latino HIV diagnoses, 2005-2007**

Year	HIV incidence	Latino HIV diag.	Lat. % of total
2005	849	22	2.59%
2006	934	23	2.46%
2007	900*	31*	3.44%*

Sources: HIV/AIDS Surveillance Branch, Alabama Department of Public Health, End of the Year Report 2005, <http://www.adph.org/aids>; Anthony Merriweather, 'HIV/AIDS in Alabama's Hispanic Community,' presentation at Alabama Statewide Roundtable, February 21, 2008; * Lani Thompson, Alabama Department of Public Health, personal communication 11/6/2008.

Table 4: **Adult and Adolescent Annual AIDS Case Rate per 100,000 Population, by Race/Ethnicity, Reported in 2006, Alabama**

Caucasian	African-American	Latino
4.9	32.5	18.3

Source: Kaiser Family Foundation, www.statehealthfacts.org

Table 5: **Rates per 100,000 population of total adults and adolescents living with HIV/AIDS in Alabama at the end of 2006**

Caucasian	African-American	Latino
111.1	619.0	210.6

Source: CDC (2008) HIV/AIDS Surveillance Supplement Report 13(1): 39-40.



DEMOGRAPHICS AND IMMIGRATION

Alabama's Latino population is among the fastest-growing in the South, attracted by jobs in agriculture, poultry and hog farms, construction, landscaping and other services, and some manufacturing jobs. Birmingham has the largest Latino population in Alabama with estimates ranging from 70,000 to 100,000.

Attitudes toward the immigrants among native-born residents are contradictory—immigrants tend to be popular in zones with a labor shortage while other municipalities have shown hostility. In Albertville in northeast Alabama, a local women's organization complained about the use of a town facility for English classes and forced its removal, ending instruction for over a hundred students.¹²

One particularly negative environment is the Birmingham suburb of Hoover where a mayoral candidate won on an explicitly anti-immigrant platform, leading to the closing of a day-laborer hiring hall known as 'La Casita.' On the other hand, the Birmingham United Way provides support to an agency serving immigrant clients.

HIV/AIDS

African-Americans comprise over 60 percent of newly detected HIV cases and overall prevalence. Latinos were barely noticed in epidemiological calculations until the second half of the current decade. The most recent HIV/AIDS planning document for the state, which covers the period from 2003 to 2008, does not disaggregate data for Latinos in its epidemiological summary.¹³

There are consistent reports of steadily increasing new HIV infections among Latinos in Alabama. A large HIV clinical care facility in Birmingham witnessed a doubling of Latino cases in the last year. Montgomery AIDS Outreach, which serves 1800 patients in two sites, reports that about 3 percent of its clients are Latinos—98 percent of them uninsured—and that two or three new Latino HIV clients appear each week.

Only 40 percent of all HIV-positive individuals of all ethnicities in Alabama are considered currently 'in care,' defined as having been seen by a doctor within the last year.¹⁴

12. Father Thomas Ackerman, St. William Catholic Church, Gunthersville, personal communication

13. 'Comprehensive Plan for HIV Prevention in Alabama 2004-2008 (Revised),' Division of HIV/AIDS Prevention and Control, Alabama Department of Public Health.

14. Anthony Merriweather, 'HIV/AIDS in Alabama's Hispanic Community,' presentation at Alabama Roundtable, Montgomery, April 21, 2008.



GOVERNMENT

The Alabama public health system is centralized. The state is divided into 11 regions with the cities of Birmingham and Mobile managing independent county health departments with substantial autonomy. The public health system of Birmingham, Alabama's largest city, once provided care for workers in the many steel mills and nearby coal mines, and the health department remains an important direct service provider.

HIV/AIDS is handled in each district by a state infectious disease officer. Nonprofits and local health departments alike are heavily dependent on Ryan White funds to sustain their operations. Alabama's U.S. senators pushed hard for the redistribution of Ryan White funding to increase resources for the South during the 2006 congressional reauthorization process.

CURRENT SITUATION

Although HIV prevention initiatives targeting Latinos are infrequent, clinical services are available for those found to be HIV-positive. Care is available in Birmingham through the St. George's Clinic within Cooper Green Hospital, a public facility. All services are free; hospitalization is not covered for undocumented immigrants although it is available on an emergency basis. Interpretation is a constant problem, and bilingual employees must sometimes be borrowed from other departments.

The largest AIDS nonprofit in the state is AIDS Alabama, which played a central role in the Southern AIDS Coalition, an advocacy network of 14 states. However, it did not have a bilingual employee as of October 2008. There are bilingual employees in AIDS service organizations in Tuscaloosa, Mobile, Anniston, Huntsville and Montgomery. The Birmingham/Jefferson County health department hired a Latino community liaison in 2006. The University of Alabama at Birmingham is home to academics experienced in research on Latino populations who have worked in HIV/AIDS projects.

A typical scenario for AIDS providers is that of Montgomery AIDS Outreach whose health district includes the high-incidence counties of Alabama's so-called "Black Belt." It employs a single bilingual case worker whose responsibilities extend into 23 counties where she is often the only interpreter available.



STRATEGIES

Outreach to Latinos in an area may depend on the energies and commitment of a single individual. Latino businesses in Alabama tend to be very cooperative with these efforts. ‘Not one store or restaurant ever told me no,’ said one employee.¹⁵ Word of mouth is key: immigrants often will patronize a private bilingual doctor trusted by residents rather than seek free services in unfamiliar health departments.

A team of Hispanic health promoters supported by a professor of medicine at the University of Alabama at Birmingham (UAB) has carried out programs on breast and cervical cancer among women’s groups as well as HIV testing at men’s soccer leagues.

A research team based at the UAB School of Nursing found Latino parents concerned with problems they face raising their children in unfamiliar, new circumstances¹⁶ and forged local links in northeastern Alabama counties to create appropriate programs.

Health initiatives serving immigrants often partner with local churches. One Catholic parish in the northeast, which holds services in Spanish and Kanjobal, a Guatemalan language, hosts a monthly meeting of county agencies to discuss Latino health issues. A Baptist congregation near Anniston in eastern Alabama runs Empower Ministries, a free primary care service one night per week. ‘La Casita,’ the hiring hall/service agency forced out of the Birmingham suburb of Hoover, was established by a Catholic parish and once performed HIV screening.

CBO NETWORKS

AIDS groups in Birmingham meet through the HIV Prevention Network led by AIDS Alabama. The Alabama Alliance for Latino Health in Birmingham addresses health issues for this population, including HIV.

The Alabama HIV Prevention Council, the state’s community planning group, has one Hispanic member out of 33.

15. Maria Shepard, personal communication, January 2007.

16. Harrison L & Scarinci S (2007) ‘Child Health Needs of Rural Alabama Latino Families.’ J Comm Health Nursing 24(1): 31-47.



ALABAMA ROUNDTABLE & RESEARCH SYMPOSIUM

The Commission convened a Roundtable on Latinos in Alabama and HIV/AIDS on February 21 in Montgomery in conjunction with the state HIV/AIDS Program and the Office of Minority Health. An organizing team comprised of key partners from the HIV/AIDS program staff, an advocacy group and a maternal and child clinic mobilized over 60 participants to an all-day session greeted by the State Health Officer, Dr. Don Williamson, who lauded the action as a response to an emerging health disparity in the state.

The meeting built on the lessons learned in a prior event held in Louisiana, which was attended by two delegates from Alabama. Successful examples of community-based research and action projects in Alabama were highlighted.

The Roundtable produced detailed recommendations in four areas: data and research; outreach; culturally

and linguistically appropriate services; and policy. One recommendation, to increase knowledge of Latino cultural differences and interpersonal relations, attracted the attention of academic partners and led to a follow-up symposium in October 2008 on applying HIV prevention research findings to the Latino population and identifying priorities for future studies, which was attended by over 100 academics, students, providers and advocates from four states. It recommended that partnerships be developed between academics and front-line workers to better understand the immigrant communities and to formulate appropriate health-promotion programs.



GEORGIA'S LATINO POPULATION
EXPLODED AFTER THE 1996 OLYMPICS
CREATED A SEVERE LABOR SHORTAGE.



GEORGIA

Table 6: **Demographic and Epidemiological Facts:**

Estimated 2007 state population (ACS):	9,545,000
Estimated 2007 Latino population (ACS)	729,000 (7.64%)
Reported HIV/AIDS cases 6/30/08	47,315

Table 7: **Georgia reported overall and Latino HIV diagnoses, 2005-2007**

Year	HIV incidence	Latino HIV diag.	Lat. % of total
2005	1,251	51	4.08%
2006	1,376	69	5.01%
2007	1,338	62	4.63%

Note: Numbers are based on data reported as of June 2008 and are not adjusted for reporting delays.
Source: Georgia HIV/AIDS Reporting System, 2008, Georgia Division of Public Health

Table 8: **Adult and Adolescent Annual AIDS Case Rate per 100,000 Population, by Race/Ethnicity, Reported in 2006, Georgia***

Caucasian	African-American	Latino
6.1	55.1	17.7

Source: Kaiser Family Foundation, www.statehealthfacts.org

(*) Unlike epidemiological reports from six other states covered in this report, Georgia's rates of those living with HIV/AIDS was not reported by the Centers for Disease Control and Prevention.



DEMOGRAPHICS AND IMMIGRATION

Georgia has the largest of the new Latino communities in the South, numbering some three quarters of a million people, over 7 percent of the state population. The largest Hispanic concentration is in the greater Atlanta area including exurban counties. The 1996 Olympic Games stimulated an early burst of Latino immigration as contractors sought cheap, short-term labor. Poultry processing plants, which have grown rapidly, are another large employer of immigrant labor throughout the state despite the ongoing crackdown on the undocumented. Statewide, Hispanic children make up nearly 10 percent of enrollment in grades K through 12.¹⁷

There are pockets of very high concentrations of Latino residents beyond Atlanta. Latinos now comprise about 25 percent of the population in the city of Gainesville in Hall County 40 miles northeast of Atlanta. Half of the city of Dalton in northwest Georgia is now Latino; they dominate the workforce in the huge carpet manufacturing industry there. Some Dalton public schools now are 80 percent Hispanic, and over half the 2400 births that

occurred in the county hospital in 2006 were to Hispanic mothers.¹⁸

Many Latino newcomers have low educational attainment: a study of over 2,000 poultry plant workers found that less than 1 percent had finished high school.¹⁹

The anti-immigrant backlash in Georgia is among the most severe in the U.S. A new law, known as '526,' took effect in July 2007 and bars non-residents from most social services while requiring police and employers to report undocumented workers. Another measure attempted to prohibit the children of unauthorized residents from school enrollment, despite long-standing Supreme Court rulings against this type of restriction. According to an advocate, the measures signaled a 'real change in the atmosphere.'²⁰ Medical personnel fear that both HIV and tuberculosis could experience an upsurge as immigrants avoid health departments around the state.

Like other areas of the South, Georgia's Latino immigrants tend to be poorly educated men of rural origin who are the first in their families to make the journey. A church service director commented that the men 'come from very oppressed situations and suddenly find themselves with money in their pockets but very isolated and lonely.'²¹

17. Georgia Department of Education <http://app.doe.k12.ga.us/>

18. América Gruner, Northwest Georgia Health Partnership, personal communication, December 2006.

19. Veronica Stowe, North Georgia AIDS Alliance, personal communication, December 2006.

20. Teodoro Maus, Georgia Latino Alliance for Human Rights (GLAHR), personal communication, December 2006.

21. Pilar Castañeda, Iglesia Espíritu Santo, Sandy Springs, personal communication, December 2006.



One particularly notorious episode relevant to HIV/AIDS work occurred in 2006 when a staff member at Atlanta's Grady Memorial Hospital reported a woman to the police for presenting a false Social Security number. The woman was arrested and faced deportation, and the story spread rapidly throughout the Latino community, further intensifying the fear of seeking health services and damaging outreach efforts.²²

HIV/AIDS

Latinos now comprise between 4 and 5 percent of the roughly 1300 new cases of AIDS reported in the state annually. Because Georgia only established mandatory HIV reporting in 2004, previous statistics are based on AIDS cases only.

Overall, HIV/AIDS in Georgia mirrors the general U.S. epidemic: concentration among African-Americans (over 75 percent of all new AIDS diagnoses), especially through homosexual transmission, with women as the fastest-growing sector in percentage terms. 'High-risk' Latinos are considered a 'special population' for epidemiological purposes in the state's Comprehensive HIV Prevention Plan 2008 although not one of the six 'priority populations.'²³

GOVERNMENT

Government response to HIV/AIDS in the state and especially in the Atlanta metropolitan area is affected by the decentralized administrative model in public health in which county boards of health are responsible for their areas and are sometimes direct providers of services. The Atlanta metropolitan area is divided into five counties (Fulton, DeKalb, Cobb, Gwinnett and Clayton), which operate with considerable autonomy.

Mid-level county officials in charge of HIV and/or STD programs in Fulton and DeKalb counties are sensitive to the specific problems facing Latino residents, including awareness of gaps in services and the desire to improve them. Gwinnett County assigns full responsibility for HIV/AIDS to a local nonprofit. However, department employees often feel they do not have strong support from their superiors, an environment aggravated by the 2007 state legislative action.

22. Greg Bautista, AID Gwinnett, personal communication, December 2006.

23. Georgia Prevention Community Planning Group, Comprehensive HIV Prevention Plan 2008 accessed Nov. 7, 2008 at <http://health.state.ga.us/pdfs/epi/hivstd/HIV%20Comprehensive%20Plan%202008%20.pdf>



CURRENT SERVICES

AID Atlanta is one of three ASOs that target Latinos in the Atlanta metropolitan area along with AID Gwinnett and Mercy Mobile Health Care. All provide at least some clinical services. Positive Impact is also available for bilingual mental health services although it suffered funding cutbacks in 2006.

AID Atlanta is the largest ASO in the city and serves about 350 active clients, 40 (11%) of whom are Latinos. It employs a bilingual outreach worker. An administrator said the case management system is inadequate for undocumented clients who face ‘many gaps in the continuum’ because of the need to prove legal residence for access to many services.

DeKalb County runs its own Ryan White clinic, combining federal funding and some private donations. Approximately 20 of its 800 clients (<3%) were Latinos in late 2006.²⁴ A Latino case manager was hired in 2006.

Fulton County’s health department is located directly across the street from Grady Memorial Hospital, which is the main hospital for the uninsured in downtown Atlanta. The legal situation has complicated their efforts: for example, since some agencies providing Ryan White

services now require proof of legal residency, the county may refer people to private charities instead.

An agency in Hall County northeast of Atlanta has been active in reaching Latino residents, who constitute a quarter of the area’s population. A large testing initiative at a local chicken plant found widespread ignorance about HIV among young people of all races and ethnicities, suggesting a decline in basic AIDS education.²⁵ Only 0.1 percent of the tests done were positive for HIV.

Latino service organizations including health providers tend to shy away from HIV. The Latin American Association serves legal residents in the Atlanta area and sometimes cooperates with HIV testing efforts. Meanwhile, HIV-positive Latinos remain reluctant to take a visible role and are anxious to keep their diagnoses a secret even from immediate family members.²⁶ Only one HIV-positive Latino in the state, a Puerto Rican professional, has gone public about his status to date.

Gwinnett County has the largest number of Latino residents in the state, and AID Gwinnett carries a caseload of 300 of whom 20 to 25 percent are Latinos. Transportation is available for locations within the county, and a nurse practitioner runs a monthly satellite clinic as an alternative.

24. Jackie Clemons, DeKalb County Health Department, personal communication, December 2006.

25. Angel Randolph, North Georgia AIDS Alliance, personal communication, December 2006.

26. Greg Bautista, AIDS Gwinnett, personal communication, December 2004.



Outreach to the large but unorganized gay Latino community in Atlanta is sporadic.

The Northwest Georgia Health Partnership affiliated with the Dalton hospital runs a weekly clinic at a local detention center. A Latino doctor reported many cases of herpes and prostatitis, possibly related to incomplete treatment of STDs in the men's home countries; he found that HIV cases detected frequently included a co-diagnosis of tuberculosis or toxoplasmosis.

A Spanish-speaking HIV-positive group sponsored by Positive Impact gathers biweekly at a local agency, the only such group known to exist in the seven-state region. At a private group interview, participants emphasized their complete ignorance about HIV prior to receiving the diagnosis. They also reported that services continue to place new obstacles in their way, such as insistence on Social Security numbers or a driver's license knowing that the undocumented will not file a complaint.

Networking among nonprofit groups occurs through the Community Planning Group meetings although many smaller nonprofits do not attend. County HIV program employees concurred that HIV-related issues are discussed horizontally but without sufficient guidance from a central authority. The Mexican consulate's health liaison officer in Atlanta hosts a monthly meeting to discuss a range of health issues and regularly sponsors health-related events.

STRATEGIES

Georgia's Office of Minority Health began a program known as "TAKE" (Take Action, Keep Educated) to eliminate health disparities among Georgia's minority populations and to help minority community-based organizations develop HIV/AIDS programs. One outcome of this initiative was the formation in 2008 of a Community of Practice (CoP) to address the special issues related to HIV/AIDS among Latinos in Georgia. TAKE created working groups in a number of areas including: service delivery, data collection, appropriate messaging, culturally appropriate school-based HIV/AIDS education; community participation; and advocacy.

OCTOBER 2008 FORUM

TAKE and the Commission convened a Forum on HIV/AIDS and Latinos in Georgia in October 2008 in Atlanta to address HIV/AIDS prevention and care issues for Georgia's large Latino population. The working groups previously established will convert the recommendations that emerged from that meeting into proposals for action.



LATINO-ORIENTED COMMERCIAL
ESTABLISHMENTS ARE OFTEN EAGER
PARTNERS IN COMMUNITY HEALTH
EDUCATION EFFORTS.



LOUISIANA

Table 9: **Demographic and epidemiological facts:**

Estimated 2007 state population (ACS):	4,293,000
Estimated 2007 Latino population (ACS)	134,000 (3.12%)
Reported cumulative HIV/AIDS cases 12/31/07	18,797

Table 10: **Louisiana reported overall and Latino HIV diagnoses, 2005-2007**

Year	HIV incidence	Latino HIV diag.	Lat. % of total
2005	1001	27	2.70%
2006	1061	36	3.39%
2007	1160	53	4.57%

Source: Louisiana HIV/AIDS Surveillance Quarterly Report, Fourth Quarter 2006, Fourth Quarter 2007, Second Quarter 2008. <http://www.dhh.louisiana.gov/reports>.

Table 11: **Metro New Orleans region reported overall and Latino HIV diagnoses, 2005-2007**

Year	HIV incidence	Latino HIV diag.	Lat. % of total
2005	361	18	4.99%
2006	301	22	7.31%
2007	383	35	9.14%

Source: Louisiana HIV/AIDS Surveillance Quarterly Report, Fourth Quarter 2006, Fourth Quarter 2007, Second Quarter 2008. <http://www.dhh.louisiana.gov/reports>.

Table 12: **Adult and Adolescent Annual AIDS Case Rate per 100,000 Population, by Race/Ethnicity, Reported in 2006, Louisiana**

Caucasian	African-American	Latino
9.5	61.4	38.8

Source: Louisiana Office of Public Health, Deborah Wendell & Sam Ramirez.

Table 13: **Rates per 100,000 population of total adults and adolescents living with HIV/AIDS in Louisiana at the end of 2006**

Caucasian	African-American	Latino
199.4	986.5	430.2

Source: CDC (2008) HIV/AIDS Surveillance Supplement Report 13(1): 39-40.



DEMOGRAPHICS AND IMMIGRATION

Demographic estimates for Louisiana remain in doubt because of the profound shifts in population that occurred after Hurricanes Katrina and Rita in August 2005, which displaced many residents. In addition, thousands of Latinos poured into the area to assist in clean-up and reconstruction labors. The city's population by the summer of 2007 had risen to just 58 percent of its pre-storm total.

Latinos are estimated to comprise about 10 percent of the population in some parts of New Orleans. A substantial number of the Latino newcomers are internal migrants coming from other parts of the U.S. Latinos also headed to the Lake Charles area in large numbers after Hurricane Rita while smaller enclaves are found throughout the state.

Many new arrivals were skilled tradesmen and came in specific waves: demolition crews followed by electricians and plumbers, then roofers.²⁷ The informal economy that employs most of them is fraught with abuse. In an ongoing Tulane University-based study, 80 percent of those surveyed said they had been cheated by a contractor at least once.²⁸ Some immigrants reportedly have

taken up residence in unhygienic abandoned buildings in the city, including those they are working on.

In contrast to the recurrent polemics on immigration occurring elsewhere in the region, anti-immigrant talk is uncommon in New Orleans, according to CBO employees, one of whom said, 'Leave the immigrants alone! We need them!' This attitude is probably influenced by the shortage of workers in the city in the months immediately after Katrina. However, immigration enforcement raids occur regularly; a downtown day-laborer recruiting site was abandoned in 2007 after a raid snared dozens while others in less visible areas continue to operate.

HIV/AIDS

New Orleans and Baton Rouge consistently rank among the top ten major U.S. metropolitan areas in AIDS case rates,²⁹ following Miami, Baltimore, Washington, D.C., New York and Memphis. New Orleans has a current HIV and AIDS caseload of approximately 5500, and Baton Rouge roughly 3600. Three-quarters of both current cases and new HIV diagnoses occur among African-Americans. Over half the new diagnoses do not carry an identified risk category. Intravenous drug use is involved in 30 percent of all cases in Baton Rouge, a high proportion for the South.

27. Fussell E (2006) 'Latino Immigrants in post-Katrina New Orleans.' Regional Seminar on Labor Rights, New Orleans, Oct 19-22, 2006.

28. Oscar Salinas, FACES, personal communication, May 2007.

29. <http://www.avert.org/usastatc.htm>



Latinos comprised 10 percent of new HIV infections in the Metro New Orleans region in early 2008,³⁰ a sharp increase that caught state planners ‘unawares.’³¹ AIDS organizations note a steady increase in HIV-positive Latino clients. The AIDS agency FACES (Family Advocacy, Care and Education Services), associated with Children’s Hospital, used to serve two Latino HIV cases annually and now receives some three new HIV-positive adult clients per month.³² The HIV Law Project providing legal advice to people with HIV has noted an increase in Latino clients who now comprise about 4 percent of its total client base.³³

Providers concur that people with HIV of all ethnicities are presenting in much worse health than they did before 2005. As is common elsewhere, many people are discovering their status after an emergency room visit for HIV-related conditions.

New Orleans is an Eligible Metropolitan Area (EMA) under the Ryan White program, and Baton Rouge is now a Transitional Grant Area (TGA) under the 2006 reauthorization, which means an increased flow of federal funds to the state. Although Baton Rouge is the state capital, some of Louisiana’s HIV/AIDS staff is located in New Orleans where the program employs several bilingual outreach workers.

CURRENT CONDITIONS

Louisiana still struggles to recover from the disasters of 2005. The main public care facility in New Orleans, the LSU-affiliated Charity Hospital, was completely destroyed, and only some of its specialty clinics have reopened in different locations. The HIV Outpatient (HOP) Clinic there was closed for over a year and now shares its space with other specialties. Only two of Metro New Orleans’ seven hospitals have reopened, and many beds assigned for HIV-related care were lost.

New Orleans’ post-storm conditions have hastened the push to mainstream HIV-related services into general medical care delivery. As a result, some AIDS services have joined the general deterioration. For example, a new requirement to use the public hospital’s pharmacy rather than the previous HIV-exclusive pharmacy has meant delays and treatment interruptions, and confidentiality is fragile due to large crowds waiting for their medications at this site. There are also fewer AIDS-specific advocates.

The city’s struggle to rebuild affects attitudes among both providers and clients. Denunciations of administrative incompetence or insensitivity at all levels of government appear regularly in the news media. A poll

30. ‘State of Louisiana Statewide Coordinated Statement of Need and HIV Comprehensive Care Plan, 2006-2009.’ <http://www.dnh.louisiana.gov/offices/misdocs>
31. Brandi Bowen, New Orleans Region AIDS Planning Council, personal communication, May 2007.
32. Dr. Claudia Medina, personal communication, May 2007.
33. Linton Carney, personal communication, April 2007.



reported in the New Orleans Times-Picayune newspaper during the week of May 14, 2007, found that the government's failings constituted the number one concern of residents, even surpassing the rising crime rate.

Lengthy delays in the distribution of \$7 million Ryan White monies received in March 2008 led to severe financial crises in some provider groups in New Orleans, including one that was forced to close its doors.³⁴ Some funds were not distributed until October.

The city has a severe shortage of addiction treatment or mental health facilities. A treatment abuse counselor called her current style of work 'guerrilla therapy.'³⁵ Injection drug use among youth without permanent housing is common, and a needle-exchange program hands out some 500 clean syringes per month. As these programs rarely have Spanish-speaking staff, few Latino youths use them.

The director of NOAIDS Task Force, the city's oldest ASO, expressed surprise at how long it has taken for New Orleans to recover. 'We were hoping that this would be an opportunity to fix what was wrong—but it hasn't turned out that way,' he said.³⁶ A health department employee quitting her position expressed com-

monly-heard discouragement over the slow pace of recovery. 'The conditions aren't new, just worse,' she said, noting that her grandchildren's class sizes averaged 50 pupils.³⁷

Primary care facilities were among the first to bounce back after the hurricanes, but a small health-advocacy and service group called current efforts 'sticking a finger in the dike.'³⁸ She described a near-total lack of attention to immigrants' chronic conditions or associated issues such as domestic violence or mental health. There are many cases of untreated diabetes and job-site injuries as well as multi-drug resistant TB.

A housing advocate predicts that the failure of promised government assistance for rebuilding and the tripling of downtown rents will cause New Orleans eventually to resemble Dallas or Atlanta with a vacant center core and the population dispersed to the suburbs.³⁹

Action to address HIV/AIDS among Latino immigrants in Baton Rouge is not visible. There appeared to be no AIDS agencies, church groups or health department staff engaged in work in this area although bilingual testing was reportedly available at one site.

34. Michael Hickerson, *In This Together*, personal communication, September 2008.
35. Drop-In Center, May 2007.
36. Noel Twilbeck, personal communication, May 2007.
37. Alicia Negron, Office of Public Health, personal communication, May 2007.
38. Gina Lutz, *Common Ground*, personal communication, May 2007.
39. Garrison Hall of Unity for the Homeless, personal communication, May 2007.



A fact-finding visit by the Deep South Project in 2007 prompted queries from one ASO about the possibility of moving a couple, both HIV-positive, and their newborn to relatives outside Louisiana. The help the couple needed—including home care for the husband and childcare assistance for his wife so that she could return to work—were said to be unavailable in Louisiana. In addition to a package of paid prenatal services from a bilingual obstetrician, they had paid an additional \$70 for her to have an HIV test, which their private doctor said produced a negative result. However, a retest at the hospital before childbirth resulted in a positive HIV diagnosis. The husband was also found to be HIV-positive and shortly afterward fell into a coma. He eventually survived but with neurological damage and blindness. No appropriate services were available for them as undocumented residents. They eventually left the state.

CURRENT SERVICES

The New Orleans metropolitan area has some services for Latino clients with HIV although residency status continues to be a barrier. Caseworkers constantly look for ways to serve undocumented persons with an HIV diagnosis. Bilingual staff is uncommon outside of New Orleans. Prevention efforts continue with a focus on reaching transient Latino males.

The main healthcare provider for people with HIV in the city is the HOP Clinic, which requires clients to present a valid Louisiana driver's license. As a result, undocumented clients often must seek services from multiple agencies during working hours. All persons have access to HIV medications through ADAP.

NOAIDS Task Force is the oldest AIDS service provider in the city. It has a Spanish-speaking doctor at its weekly clinic and one bilingual case manager and usually can count on volunteer interpreters for its testing services. N'R Peace in the Westbank section of the city also provides all primary clinical services.



The state HIV/AIDS program initiated direct outreach to Latino day laborers with two bilingual staff. Most of the men contacted had either no prior knowledge about HIV or labored under misconceptions.⁴⁰ Mobile vans visit the sites on a regular schedule, as does a nonprofit sidewalk clinic that offers protective work gear, primary and wound care, vaccinations and herbalist services.

Primary care clinics often employ bilingual staff, but services to the uninsured or undocumented are inconsistent. Advocates often must contact clinic directors on behalf of Latino clients who have been refused treatment.

The directory of services will say that undocumented residents can use a certain facility, but then the front desk personnel refuse them. Government employees are on the lookout for undocumented people even when it is legal for their children to have a benefit.
—Gina Lutz

FACES, a fully bilingual pediatric AIDS program funded through Ryan White Part D at Children’s Hospital, now manages a client roster of 350, down from 600 before Katrina of whom 10 percent are Latinos. About 80 percent of their clients are women. FACES offered free Spanish classes to all HIV providers in the city in 2006 as well as cultural sensitivity workshops on religion, family, sexual orientation, immigration and similar topics.

I have this understanding I have heard this before, 15 years ago.... This happened to African-Americans, materials not being culturally appropriate, providers not knowing how to provide services. And I see the same thing occurring to Hispanics. . . . Since that time we learned how to provide services to African-Americans, and we may try to use those best practices for Latinos.—Michael Hickerson, In This Together

STRATEGIES

Some primary care facilities are responding to the huge demand for bilingual providers. Several large health companies such as the Ochsner Health System have developed new services targeting Hispanic consumers. The St. Charles Community Health Center in suburban Kenner maintains bilingual services as do walk-in clinics near the French Quarter. HIV testing in Spanish sometimes can be obtained in these sites.⁴¹ However, the safety-net clinics are said to be ‘at capacity,’ and mental health services for any population are virtually non-existent.⁴²

A March of Dimes-funded project began in June 2007 to provide prenatal services to Latina women via a mobile unit as many Latina women still give birth without prenatal care.

40. Alicia Negrón, Office of Public Health, personal communication, May 2007.
41. We tested the availability directly by taking a colleague who pretended not to understand English and were told to come back another day.
42. Dr. Claudia Molina, FACES, personal communication, May 2007.



There appear to be no organized Latino advocacy or health promotion groups in the state outside of New Orleans.

CBO NETWORKS

The Latino Health Access Network is a coalition of providers, charities, churches and individuals formed to increase access for the Latino population. The group encourages clinics to plan for integrating those now outside the care system into medical care and to make their services more Latino-friendly.

The Louisiana Latino Health Coalition for HIV/AIDS Awareness (LLHC) is comprised of bilingual providers and other participants sympathetic to the issue.

The independent Louisiana Public Health Institute (LPHI) acts as a neutral convener to promote health initiatives and has taken an active role in HIV/AIDS issues and in the efforts to restore the city's health systems.

THE LOUISIANA ROUNDTABLE

Several local partners joined the Commission to hold a statewide Roundtable on Latinos and HIV/AIDS in October 2007 in Alexandria in central Louisiana with strong support from the Office of Public Health HIV/AIDS program. The meeting drew over 60 participants from all corners of the state. The LLHC was charged with providing leadership to the state on the recommendations that emerged from the event.



ONE OF THE FASTEST-GROWING LATINO ENCLAVES IS ALONG THE GULF COAST WHERE CLEAN-UP AND RECONSTRUCTION REQUIRED THE SERVICES OF EXPERIENCED DEMOLITION WORKERS, ROOFERS, CARPENTERS AND OTHER SKILLED LABORERS.



MISSISSIPPI

Table 14: **Demographic and epidemiological facts:**

Estimated 2007 state population (ACS):	2,919,000
Estimated 2007 state Latino population (ACS)	73,000 (2.50%)
Reported cumulative HIV/AIDS cases (12/31/07)	8,806

Table 15: **Mississippi reported overall and Latino HIV diagnoses, 2005-2007**

Year	HIV incidence	Latino HIV diag.	Lat. % of total
2005	577	32	5.55%
2006	599	37	6.18%
2007	611	19	3.11%

Source: Mississippi Department of Health Office of STD/HIV, personal communication 8/4/2008.

Table 16: **Adult and Adolescent Annual AIDS Case Rate per 100,000 Population, by Race/Ethnicity, Reported in 2006, Mississippi**

Caucasian	African-American	Latino
4.7	32.3	50.8

Source: Kaiser Family Foundation, www.statehealthfacts.org

Table 17: **Rates per 100,000 population of total adults and adolescents living with HIV/AIDS in Mississippi at the end of 2006**

Caucasian	African-American	Latino
116.7	647.9	300.6

Source: CDC (2008) HIV/AIDS Surveillance Supplement Report 13(1): 39-40.



DEMOGRAPHICS AND IMMIGRATION

Mississippi has a newer and smaller Latino population than the other states of the Deep South Project. Its numbers grew sharply after the two major hurricanes of 2005 as clean-up laborers moved into the Gulf of Mexico and southeastern Mississippi. Before the recent wave of immigration, Jackson, the capital, was home only to some 500 Latino residents, who now are estimated to number as many as 40,000.⁴³

Smaller Latino enclaves exist in other parts of the state where work in farm labor and in agribusinesses such as catfish, hog and chicken farms is plentiful. Casinos are another source of jobs in Vicksburg and the Mississippi Delta near Memphis.

Large Hispanic settlements also have sprung up in Gulfport, Biloxi and other coastal communities as well as in Hattiesburg, Laurel and Meridian to the north where hurricane damage also was substantial. Hattiesburg, whose overall population grew by one quarter when displaced persons moved north, saw its Latino component of the total rise from 1 percent to somewhere between 5 and 7 percent.⁴⁴ A Catholic priest in Hattiesburg reported that attendance at a Spanish-language mass rose from about 25 in the year 2000 to nearly 300 after the

hurricanes. Hispanic baptisms outnumber others at his church by 5 to 1.

An estimated 70 percent of Mississippi Latinos are Mexican, followed by Central Americans and a few from Ecuador, Peru, Colombia and Cuba. There is also substantial internal migration from Louisiana and Texas.

As is common throughout the country, employers take advantage of the cheap labor force while fearful of the increasingly stiff penalties for hiring the undocumented. One result is that employers use subcontractors to hire short-term workers thereby providing a legal screen for large industries; these workers switch jobs regularly before their invalid identity documents are discovered.

Anti-immigrant sentiment has led to legislative action in the state. Governor Haley Barbour signed into law the Mississippi Employment Protection Act in March 2008, which imposes heavy fines for employment of undocumented workers. An August 2008 raid at the Howard Industries transformer plant in Laurel in southeastern Mississippi resulted in the arrests of nearly 600 mostly Latino workers.

Community attitudes toward the immigrant newcomers are uneven, and there is a marked difference between hurricane-affected zones and the rest of the state. A

43. Luis Espinoza, editor of *La Noticia*, personal communication, December 2007.

44. Kathy Garner, personal communication, December 2007.



Gulf Coast church leader characterized local attitudes as ‘not much animosity and some paternalistic willingness to help.’

Although all persons living with HIV are eligible for state HIV programs, including case management, housing and ADAP, these rights are not always respected in Mississippi. Officials and providers state that the undocumented can obtain services but that the client must be ‘willing to make certain compromises’ such as trying a different county when services are refused in a given health department.

The most urgent perceived need is access to a driver’s license. Police activity is becoming more aggressive toward immigrants, and roadblocks for driver’s license checks are common.⁴⁵

HIV/AIDS

The state reported 611 new HIV infections for the year 2007, a decline from around 700 annually in the mid-1990s. Forty percent of all HIV-positive persons in Mississippi live in the Jackson/Hinds County area, followed

by the Gulf Coast region including Gulfport, Biloxi and several surrounding counties.

About half of the state’s 8,540 known HIV-positive individuals are considered to be ‘in care,’ defined in Mississippi as at least one clinical visit every six months. At the same time, as many as one-third of all enrolled ADAP patients of all ethnicities do not pick up their medication on a regular monthly basis.⁴⁶ Possible motives mentioned are fear of stigma, transportation problems and other issues, all highly relevant factors for Latino clients.

Mississippi historically has suffered from very high STD levels, and statistics show a mixed record in recent years. The state’s syphilis case rate was the highest in the nation in 1997 but fell sharply five years later⁴⁷ while Chlamydia and gonorrhea rates remain elevated.⁴⁸ Hispanics in Mississippi have higher STD rates overall than Caucasians.

Latinos comprised only about 1 percent of total HIV cases in the state, but 3 percent of newly reported infections in 2007. A provider noticed a sharp shift in recent new infections to a younger population,⁴⁹ which could be the result of better testing practices or an indication of infections occurring during adolescence.

45. Personal observation outside Gulfport, Mississippi, where Caucasian drivers were waved through a roadblock.

46. Eva Thomas, Mississippi ADAP Coordinator, personal communication, December 2007.

47. Mississippi Department of Public Health: http://www.msdh.state.ms.us/msdhsite/_static/14,0,150.html

48. Painter TM (2007) ‘Connecting the Dots: When the Risks of HIV/STD Infection Appear High But the Burden of Infection Is Not Known—The Case of Male Latino Migrants in the Southern United States.’ *AIDS Behav* online DOI 10.1007/s10461-007-9220-0. The statistics are cited from a Kaiser Family Foundation study no. 6062 ‘HIV/AIDS and other Sexually Transmitted Diseases in the Southern Region of the United States.’

49. Leandro Mena, Crossroads Clinic, Jackson, Mississippi, personal communication, December 2007.



GOVERNMENT

Many public health services in Mississippi are provided at the county level with state funding. County health officers enjoy wide latitude and autonomy; program directors based in Jackson have little enforcement power and may be overruled locally in some cases. This is particularly relevant in the case of providing services to non-residents where state guidelines may not be uniformly applied. Even monitoring may be difficult if state and local officials do not share criteria.

ADAP waiting lists have been eliminated; the state STD/HIV web page directs people ‘who are not eligible for Medicaid benefits’ to contact the ADAP program without reference to residency status.

The main AIDS provider organizations are located in Jackson and in the southeastern part of the state including the Gulf Coast. Little independent nonprofit activity related to HIV/AIDS was found in the northwest (Delta) region or in smaller cities.

Primary health care for the indigent in Mississippi is handled by federally funded clinics or county health departments. A few federal clinics have HIV case management available, but low reimbursement levels are a

disincentive.⁵⁰ The state recently obtained federal funding to create new HIV specialty clinics in Grenada and Natchez.

CURRENT CONDITIONS

Mississippi is a relatively poor state with traditionally a weak government role in providing social services. It has among the nation’s worst general health statistics; for example, although infant mortality among African-Americans is declining nationally, Mississippi’s rate continues to rise.

The state STD/HIV program has embraced the enhanced HIV prevention guidelines issued by the Centers for Disease Control and Prevention (CDC), including both expanded HIV testing and aggressive screening for Chlamydia and gonorrhea as key co-factors.⁵¹

Most HIV-positive Latinos are first diagnosed through emergency room visits, during prenatal care or at the federally-funded Crossroads STD Clinic, associated with the University of Mississippi Hospital in Jackson. They are all referred into care at the Adult Special Care unit with Dr. Leandro Mena, a Dominican M.D. and one of the few bilingual providers in the state. Dr. Mena stated that among his patients there is ‘a group that does

50. Mark Colomb, My Brother’s Keeper, Jackson, Mississippi, personal communication, December 2007.

51. http://www.msdh.state.ms.us/msdhsite/_static/14,0,150.html



well and another that doesn't.' Women tend to respond better as they have services through Part D (formerly Title IV) of the federal Ryan White AIDS Program, including comprehensive case management. Most Latino HIV clients have T-cell counts below 200.

Three-quarters of all Latino HIV patients in Mississippi are uninsured; the remainder are Medicaid recipients at the moment of diagnosis. The HIV hotline can take calls in Spanish.⁵²

As many as a third of the Jackson clinic's Latino HIV patients are out of the city or the state at a given time pursuing work opportunities. Because men may change identities frequently, some patients have several aliases, which complicates record-keeping. But they enjoy the advantage of a 'one-stop shop' since Crossroads and the HIV clinical facility are so closely linked.

A study carried out by the Delta AIDS Education and Training Center in New Orleans on the needs of minority clients in Mississippi found that HIV providers were not knowledgeable about interactions between medicinal plants often used by Latinos and HIV medications.⁵³ The researcher also found a lack of tools for risk behavior assessment and screening unless these were relevant to the patient's motive for consulting a doctor.

Immigrants are unable to obtain affordable care for chronic care issues, such as diabetes, hypertension, smoking-related illnesses, and drug and alcohol abuse. The University hospital system in Jackson has some programs for the undocumented, but they are underfunded and 'not easy to get into,' according to a hospital interpreter.⁵⁴ Transportation is also a huge issue for many especially as driver's licenses cannot be obtained by the undocumented.

CURRENT SERVICES

The University Medical Center in Jackson recently hired medical interpreters and has posted signs in Spanish. A bilingual nurse monitors compliance with language access policies.

The Gulfport/Harrison County Hospital now has staff interpreters and no longer urges patients to provide their own. It also extended service hours at its STD clinic to one evening a week to accommodate Latino clients. Coastal Family Health, a primary care provider with eight facilities throughout the Gulf region, has an interpreter at one clinic as well as a bilingual provider who sees patients once a month.

52. Dr. Leandro Mena, personal communication, December 2007.

53. Bryson Williams presentation at Mississippi Care and Services Advisory Group, Jackson, Dec 7, 2007.



Officials suggest that their allies in the state legislature will support the STD/HIV Bureau's efforts but in exchange require the program to 'stay out of the limelight' and keep a 'very low profile.' A sign of the difficult environment was the opposition by a former health commissioner to the opening of a new HIV clinic due to ideological objections related to the disease transmission routes.

Outreach for HIV prevention education among Latinos is ongoing in the Biloxi and Hattiesburg areas. The Southeast Mississippi Rural Health Initiative (SeMRHI) in Hattiesburg employs bilingual providers and a medical interpreter and co-sponsored a short-term intervention in 2007 to raise awareness of the issue (*Hazte la Prueba*).

The Mississippi state health department deploys a Mobile Medical Clinic that visits rural and isolated populations for STD screening and other basic health check-ups.⁵⁵

Health fairs are a common way to inform immigrants about health-related services although none have been held in Jackson since 2006.

STRATEGIES

The Delta AIDS Education and Training Center based in New Orleans recommended that horizontal relationships among agencies and providers in Mississippi's rural areas be strengthened so that a network of clinics emerges that can coordinate their strategies on HIV-related issues. Minority providers will be essential to the success of this networking initiative.

Dr. Mena proposes a version of the WHO 'health liaison' model in which a community leader receives payment for contacting newcomers, informing them about health issues, getting them screened and referred them to basic treatment.

No HIV-positive Latino support groups exist in the state although a new group for all persons living with HIV announced its formation in Jackson in October 2008.

Evidence-based prevention interventions supported by the CDC have not worked among Latinos so far in the state. A group in Hattiesburg attempted in 2006 to construct a program based on a peer education program known as 'Popular Opinion Leaders' but could not find the right individuals among the target population to play this role.⁵⁶ The failure illustrates the need for new

54. Eloise Lopez, personal communication, December 2007.

55. http://www.msdc.state.ms.us/msdcsite/_static/14,0,150.html

56. Kathy Garner, personal communication, December 2007.



strategies to address highly transient populations that are not currently served by the existing compendium of interventions aimed at more stationary groups through regular workshops or similar activities.

However, more recently the state HIV/STD program worked successfully with local partners in Hattiesburg to mount an effective HIV education and testing campaign among Latinos in response to a rise in syphilis cases.

The state currently has two community-input panels, the Ryan White-mandated Community Planning Group (CPG), which focuses on prevention, and the Care and Services Advisory Group (C&S). There is an ongoing dispute about combining the two into a single Mississippi HIV Planning Partnership as has been done in other states. This idea is quite unpopular with the nonprofit representatives who feel that important community voices will be lost and are uncomfortable with mixing prevention and care issues in one body. Government officials express frustration at the two groups' slow procedures and duplication of planning efforts and believe the merger could greatly improve effectiveness.

Many agencies and providers would like to better serve Latino clients but have not found the right way to open their doors to them. "I want to have the need for a translator," said Kathy Garner of Hattiesburg's AIDS Service Center.

THE GULF COAST ROUNDTABLE

Forty CBO and health department representatives along with advocates and other concerned individuals met on April 22, 2008, to review the current situation and formulate recommendations. Delegates also attended from Louisiana and Alabama. Craig Thompson, Director of the STD/HIV Bureau of the Mississippi Department of Public Health attended in support along with Scott Carson, Director of the Care and Services Division of the Bureau. The session was held in the Gulf Coast city of Biloxi where hurricane-relief agencies had been active in responding to the many needs of Latino recovery and reconstruction laborers.

Participants emphasized the need for basic language and translation services in all clinical sites, including better dissemination of available in-person and phone-line interpreting services. They laid plans to build a closer network among providers in the Gulf counties to coordinate efforts among hospitals, safety-net clinics and AIDS provider groups. The state STD/HIV Bureau pledged its ongoing support to these efforts.

BIRTH RATES AMONG LATINOS ARE HIGHER
THAN NATIONAL AVERAGES, AND SOME
SCHOOL DISTRICTS NOW HAVE LARGE
ENROLLMENTS OF BILINGUAL STUDENTS.





NORTH CAROLINA

Table 18: **Demographic and epidemiological facts:**

Estimated 2007 state population (ACS):	9,061,000
Estimated 2007 Latino population (ACS)	640,000 (7.06%)
Reported HIV/AIDS cases 12/31/07:	21,593

Table 19: **North Carolina reported overall and Latino HIV diagnoses, 2005-2007**

Year	HIV incidence	Latino HIV diag.	Lat. % of total
2005	1806	125	6.92%
2006	2147	171	7.96%
2007	1943	160	8.23%

Sources: Surveillance Reports, North Carolina Division of Public Health, HIV/STD Prevention & Care Branch, 2005, 2006, 2007, <http://www.epi.state.nc.us/epi/hiv/>; Bill Jones, Epidemiologist, Communicable Disease Branch, 8/18/2008.

Table 20: **Adult and Adolescent Annual AIDS Case Rate per 100,000 Population, by Race/Ethnicity, Reported in 2006, North Carolina**

Caucasian	African-American	Latino
5.3	54.8	23.8

Source: Kaiser Family Foundation, www.statehealthfacts.org

Table 21: **Rates per 100,000 population of total adults and adolescents living with HIV/AIDS in North Carolina at the end of 2006**

Caucasian	African-American	Latino
98.0	912.7	217.6

Source: CDC (2008) HIV/AIDS Surveillance Supplement Report 13(1): 39-40.



DEMOGRAPHICS AND IMMIGRATION

The Latino population of North Carolina is now estimated to be well over a half-million. The state has long had a temporary farm-laborer population that follows the harvests along the eastern migrant stream originating in Florida. These workers historically also took many construction, poultry and meat processing jobs; but as they began to be drawn away to higher paying jobs by the state's rapid economic growth, a severe labor shortage ensued, and tens of thousands of permanent immigrants flocked to the state.

Some 15 of the state's 100 counties have substantial Hispanic populations at present, including all major metropolitan centers such as Charlotte, the Triangle area (Raleigh, Durham and Chapel Hill), the Triad area (Winston-Salem, Greensboro and High Point), Fayetteville, Greenville and Asheville.

Current demographic data may not be reliable. For example, the stated fertility rate for Latinas in North Carolina is higher than that of the Mexican state of

Chiapas, which suggests that the Latino population of the state is still grossly underestimated.⁵⁷

Residents describe a shift in attitudes among native-born North Carolinians toward Latino newcomers from early complaisance to increasing resentment. The state allowed residents to obtain driver's licenses without proof of legal residency, an opportunity utilized by other immigrants in neighboring states until it was revoked in 2006. In 1999 Governor Mike Easley appointed a Latino affairs advisor, and his wife Mary Easley chaired a Latino Health Task Force. Although the Task Force's work was considered uncontroversial at the time, the co-sponsor of the initiative, a Latino advocacy group called El Pueblo, was later the object of an intense attack, including hate mail and threats that led to the resignation of its then executive director.

Police agencies also manifest conflicting views and approaches. Some rural sheriffs welcome the additional role of immigration enforcement while others object to this function. Durham's retiring chief of police refused to perform immigration-related work, arguing that crime-fighting requires trust between the populace and law enforcement officers.⁵⁸

57. Leonardo Uribe, Duke University, personal communication, July 2007.

58. Steven Chalmers, Durham Police Department, personal communication, July 2007.



HIV/AIDS

North Carolina is one of the first southern states to recognize the health disparity reflected in the steady rise of Latino HIV cases in the state, now at about 9 percent of all reported new infections. This development was crucial in the 2008 launch of the state's Latino HIV/AIDS Initiative.

Nearly one quarter (83 of 345) of all incident tuberculosis cases in 2007 were found among Hispanics.⁵⁹ Now, 10 percent of persons with new HIV diagnoses are co-infected with TB, and the state health department is encouraging greater cooperation between its TB and HIV programs. TB and HIV co-infections are common worldwide, and each of the two diseases worsens the impact of the other. In addition, the medications used for TB may interact negatively with some HIV treatments.

GOVERNMENT

The HIV/STD Prevention and Care Branch is located in the Epidemiology Section of the Division of Public Health. In 2007-08 the Branch opted for an ambitious program of community mobilization around Latino HIV/AIDS issues throughout the state.

While the state promotes activating Latino community resources to encourage HIV awareness and testing, others question whether this drive can occur without an influx of new resources. Bicultural community leaders are wary of being tapped to fulfill the state's implementation goals with regard to HIV/STDs and other programs as an inexpensive substitute for new funded programs with explicit commitments of continuing support.

You have a few key people who are engaged with the [Latino] community and know what they're doing. But they're being stretched in every direction for all sorts of programs. —Yvonne Torres, Wake County HIV/AIDS Program, Raleigh

59. Presentation at North Carolina Latino HIV/AIDS Initiative Task Force meeting, May 29, 2008, Raleigh.



CURRENT CONDITIONS

North Carolina can count on a considerable resource base for providing care and prevention services to Latino residents, including agencies and health departments with experienced bilingual staff, Latino service organizations, researchers focusing on the emerging Latino communities, farm labor advocates and Latino community organizers with deep historical roots in their respective regions.

A North Carolina researcher found that fear dominates the health-seeking decisions of Latinos.⁶⁰ Even when medical or mental health care is available, many immigrants remain skeptical that they will be served or believe that they will risk becoming known to authorities.⁶¹ When medical care is urgent, immigrants tend to rely on safety-net providers or hospital emergency rooms. One Durham facility reports that its clientele is now one-third Latino.

For HIV-related care North Carolina offers a variety of options, from county health departments to specialized clinics associated with the state's many universities, such as the Duke AIDS Research and Treatment Center

(DART). The large university clinics often have bilingual staff and run many research trials seeking participation from Latinos.

CURRENT SERVICES

Some of the larger cities in North Carolina are home to agencies with bilingual outreach workers and/or clinicians. Testing is also available with Spanish-speaking counselors in several counties.

For AIDS case management 'bridge counselors' perform the initial work of getting new clients into medical and social services. This system evolved because case managers could not keep up with all the new clients, and too many people were lost to care. In lieu of contact tracing, Disease Intervention Specialists throughout the state are charged with helping new patients to find care and to inform their intimate partners about the diagnosis.

Spanish-speaking outreach workers encourage testing in some cities. A Wake County (Raleigh) door-to-door HIV and STD testing program enjoys a 90 percent acceptance rate except among women when male relatives

60. Emilio Parrado, Duke University, personal communication, July 2007.

61. Mary DeKoster, Durham County Health Department, personal communication, July 2007.



are in the home.⁶² Positive tests tend to be rare although more common among commercial sex workers, according to program staff.

Wake County also has an innovative STD education program at its county jail run in conjunction with researchers at the University of North Carolina. The two-week workshop involves intensive discussion about health and gender with male inmates using popular Latin music and other cultural artifacts.

Health fairs are a popular strategy to reach Latino enclaves. Many informational services and tests can be offered at fairs, and those screened referred onward. Some groups use the lay health provider (*promotores*) model in different forms in which community members are trained and mentored to provide health information to their peers.⁶³ Churches also may organize health programs to assist recent immigrants. For example, a health promoter project was established in Raleigh through El Pueblo focusing on families and children; STI education was later added.

Latino social services agencies, though rare, are promising vehicles for providing HIV/AIDS orientation and

prevention education. El Centro Hispano in Durham is a community-based organization with approximately 900 dues-paying members located in a refurbished downtown building across from the Latino Community Credit Union. The existence of these two entities side by side in a prominent location provides a strong welcoming signal for immigrants as bank accounts, car loans and even mortgages can be obtained there.

El Centro Hispano also hosts a gay-oriented prevention program strategy and exported it to neighboring cities briefly. The outreach is an unusual achievement for Latino groups anywhere in the South.

Another creative approach is the initiative run from Wake Forest University's public health school to provide STD education to Latino men through their soccer leagues.⁶⁴ This ongoing project is being monitored carefully for possible replication elsewhere.

62. Donna Rzewnicki, Wake County Health Department, personal communication, July 2007.

63. Rhodes SD, Foley KL, Zometa CS & Bloom FR (2007) 'Lay Health Advisor Interventions Among Hispanics/Latinos: A Qualitative Systematic Review.' *Am J Prev Med.* 33(5): 418-27.

64. Rhodes SD, Eng E, Hergenrather KC, Remnitz, IM, Arceo R, Montañó J, Alegría-Ortega J (2007) 'Exploring Latino Men's HIV Risk Using Community-based Participatory Research.' *Am J Health Behav* 31(2): 146-58.



STRATEGIES

The state's main goals were articulated in January 2008 with the launch of its Latino HIV/AIDS Initiative: increased awareness of the disease, broader testing and earlier detection of HIV infections. Its 2008 statewide 'Get Real, Get Tested' campaign included bilingual advertising.

Another strategic goal for the state is to develop working models that can be disseminated elsewhere in the region, as occurred with the state's own successful adaptation of the Popular Opinion Leader intervention for black gay men.

A Duke University research team pursued the idea of constructing an HIV prevention intervention that would take an apartment block, rather than a fixed population, as its unit of measurement given that the high degree of mobility of the individuals in immigrant enclaves requires different approaches and measurements of success. Although the concept has yet not been tried, it is an innovative potential health promotion and education model for Latino neighborhoods.

Many respondents emphasized the need to integrate HIV education not only with general health care access but also with other pressing issues that affect the population, such as depression, social isolation, substance abuse and domestic violence. They note that the stress of family separation and solitude weighs especially heavily on married men without their partners.

Spanish-language newspapers and radios abound throughout the state. A popular television program available in most North Carolina cities and two South Carolina markets entitled 'Nuestro Barrio' presents information on health and other topics in a simple and didactic style. It is produced by the Durham-based Community Reinvestment Association of North Carolina (CRA-NC).



THE NORTH CAROLINA LATINO HIV/AIDS INITIATIVE

The Initiative is an ambitious, multilevel campaign to incorporate the issue into the work of the health departments throughout the state. Based on a previous experience mobilizing counties to improve readiness for bioterrorist attacks, extensive initial contacts were made with county officials and community partners throughout the state to join the efforts. Increased HIV screening among Latino residents was a first step.

At the forum that launched the project in January 2008, state officials called for preemptive action to ‘change the course of the HIV/AIDS epidemic in North Carolina’s Latino community.’ A permanent Steering Committee was formed with four state employees and four community representatives in addition to a 24-member Task Force to guide the Initiative. Its four announced goals are:

- To increase Latino access to HIV/AIDS testing, prevention and care services;

- To improve linguistic and cultural competency of programs for Latinos;
- To obtain broad community involvement and leadership from within the Latino community on HIV-related efforts; and
- To strengthen collaboration with research centers to further the understanding of the HIV epidemic among Latinos and evaluate effectiveness of the Initiative in accomplishing its goal and objectives⁶⁵.

At a July 2008 follow-up meeting on the Initiative in Raleigh, the Steering Committee’s recommendations were outlined: a needs assessment on testing availability to be carried out by the HIV/STD Prevention and Care Branch; increased participation of Latinos in the state’s Community Planning Groups; identification of best-practices and programs for Latinos; translation of ADAP-related documents into Spanish; revision of state licensing policies to facilitate entry of bicultural, foreign-educated professionals into the care system; cultural/linguistic competency trainings; and an increase in the number of bilingual Disease Intervention Specialists in the state.

65. Felizzolla J (2008) ‘North Carolina Latino HIV/AIDS Initiative: A Statewide Response to an Increasing Epidemiological Trend of HIV Disease Cases among Latinos.’ (PowerPoint) North Carolina DHSS Communicable Disease accessed at: www.latinoaids.org/programs/southproject/docs



MANY MORE LATINO MEN
THAN WOMEN LIVE IN THE
DEEP SOUTH AS THEY TEND
TO BE THE FIRST TO ARRIVE.



SOUTH CAROLINA

Table 22: **Demographic and epidemiological facts:**

Estimated 2007 state population (ACS):	4,408,000
Estimated 2007 state Latino population (ACS)	166,000 (3.76%)
Reported HIV/AIDS cases (12/31/07)	17,384

Table 23: **South Carolina reported overall and 'Other' HIV diagnoses, 2005-2007**

Year	HIV diagnoses	Latino HIV diag.*	Others % of total
2005	773	41	5.30%
2006	782	47	6.01%
2007	774	49	6.33%

Source: STD/HIV Division Surveillance Report, South Carolina Department of Health and Environmental Control, December 2005, December 2006, December 2007, <http://www.epi.state.nc.us/epi/hiv> <<http://www.epi.state.nc.us/epi/hiv>> www.scdhec.net/health/disease/stdhiv/docs <<http://www.scdhec.net/health/disease/stdhiv/docs>> .
 *'Others' includes Hispanics, Asian/Pacific Islanders and Native American. The cumulative Hispanic-only proportion of total cases in South Carolina is estimated by DHEC to be 2.1%.

Table 24: **Adult and Adolescent Annual AIDS Case Rate per 100,000 Population, by Race/Ethnicity, Reported in 2006, South Carolina**

Caucasian	African-American	Latino
5.8	52.8	27.6

Source: Kaiser Family Foundation, www.statehealthfacts.org

Table 25: **Rates per 100,000 population of total adults and adolescents living with HIV/AIDS in South Carolina at the end of 2006**

Caucasian	African-American	Latino
133.8	978.6	278.8

Source: CDC (2008) HIV/AIDS Surveillance Supplement Report 13(1): 39-40.



DEMOGRAPHICS AND IMMIGRATION

South Carolina has received a rapid influx of Latino residents, whose numbers have at least tripled in the last ten years. The growth has been particularly sharp in the resort and retirement communities of Myrtle Beach and Hilton Head Island where immigrants came to work in construction and services. Some counties near Hilton Head have experienced 10- to 15-fold increases in their Hispanic populations in the last decade. According to an AIDS service provider, all local contractors use Latino immigrants: ‘Everything would grind to a screeching halt without them.’⁶⁶ Spanish-speaking students now comprise 24% of enrollment in the public schools on Hilton Head Island.

However, legal tightening has affected the work opportunities that once drew the immigrants to the state. Some Hilton Head businesses have sought workers with temporary visas from Asia and Eastern Europe to fill service jobs after immigration raids led to fines. A provider estimates that about 7,000 immigrants work on the island, especially in the large gated communities known as ‘plantations.’ However, so many immigrants have ar-

rived that temporary jobs are now scarcer.⁶⁷ Men typically earn \$200-300 a week as temporary workers.

Mexicans are the most numerous among the immigrants, but there are also many Hondurans, Colombians, Venezuelans and Argentines. Guatemalans, some of whom speak local dialects and are not fluent in Spanish, dominate in other zones and are often employed in the poultry industry. The director of a volunteer clinic said that a new trend in response to the increasing difficulties of crossing the border is the simultaneous immigration of entire families and a resulting rise in Latino births. Because men cannot go back and forth as easily as before, they are more inclined to bring the entire family with them to the state for longer stays.

Haitian and Mexican migrant farm workers are another regular presence in the state. Labor camps sometimes are fenced in to avoid assaults on the migrants and to prevent workers from leaving the fields for better-paying jobs elsewhere.

Attitudes toward the newcomers are ambiguous. Anti-immigrant measures are less draconian where dependence on migrant labor is high such as in the resorts and

66. Stan Stolarczyk, ACCESS Network, July 2007.

67. Luis Bell, Latin American Association of South Carolina, personal communication, July 2007.



the agricultural zones near the coast. The municipal government of Hilton Head authorized the operation of a hiring hall, in part to reduce complaints about the presence of potential day laborers in public zones. Entities that serve immigrants also receive support from the Hilton Head Island Foundation.

Nonetheless, a South Carolina health department official stated that the negative public discourse on immigration was pervasive enough to set back their work. Raids were more frequent, and health department staff had had to intervene to obtain the release of HIV patients. The issue of inadequate care or even life-threatening negligence of detained immigrants with HIV/AIDS in U.S. facilities was covered by a Washington Post series in May 2008 and a critical report by Human Rights Watch in 2007.⁶⁸ ‘We’ve been trying to gain their trust, and now a lot of them have withdrawn and become skeptical again,’ said the official.⁶⁹ She added that immigrants are now more reluctant to attend public health fairs.

The biggest factor now is the mistrust. People used to be very friendly—one would come for testing and bring his friends. Now they doubt our purposes.
—Barbara Charles, South Carolina STD/HIV Program

The anti-immigrant law that took effect in Georgia in July 2007 has led immigrants living in border areas of South Carolina to avoid shopping across the state line in Savannah for fear of arrest.

HIV/AIDS

Over 70 percent of all new AIDS diagnoses in South Carolina are among African-Americans.⁷⁰ The racial/ethnic category ‘other’ comprised 5.5 percent of the new cases although the estimated Hispanic proportion of the state population is only about 3.5 percent. There is generalized uncertainty about what this statistic means and may reflect some confusion in the way Hispanics are identified for epidemiological surveillance purposes.

HIV screening is a high priority for the state program. The years 2006-07 registered a decline in testing of Spanish-speaking residents partly due to a change in testing technology, the end of certain community-based testing programs and the elimination of interpretation services after a round of budget cuts in 2006.

68. Priest D & Goldstein A (2008) ‘Careless Detention: Medical Treatment of Immigrants.’ Washington Post, May 11-14, 2008; Human Rights Watch (2007).

‘Chronic Indifference: HIV/AIDS Services for Immigrants Detained by the United States.’ 19(5): G.

69. Barbara Charles, SC Dept of Health and Environmental Control, personal communication, July 2007.

70. ‘STD/HIV Division Surveillance Report, December 31, 2007.’ South Carolina Department of Health and Environmental Control.

http://www.scdhec.net/health/disease/stdhiv/docs/HIVSTD%20surveillance%20report_12312007.pdf



Pockets of high HIV rates among Latinos have been detected. ACCESS reported in 2007 that its 255-person caseload in Hilton Head included 18 Latinos, or 7 percent of the total, compared with no Latino cases in 2002.⁷¹

Beaufort-Jasper-Hampton Comprehensive Health Services (BHJ) has an HIV patient caseload of 240 of whom 40 are Hispanic, or 16 percent of the total.⁷² BJH, a federally-funded community health center, has registered a recent upsurge of Hispanic clients many of whom come in with low CD4 counts indicating a late stage of HIV infection.

Fifty-eight percent of all Hispanic males diagnosed with HIV in South Carolina during the period 2005-06 fell into the 'No reported risk' category, much higher than the norm (cf. 19 percent among Caucasians and 29 percent among African-Americans).⁷³ Most Hispanic females with HIV are detected in the context of prenatal care.

Sixty percent of Hispanics known to be HIV-positive in the state are not in care, compared to 47 percent among Caucasian clients and 44 percent among African-Americans.⁷⁴

Testing is mandatory in South Carolina upon entry to prison but not in jails, and 5 percent of all new HIV diagnoses detected in the state are found among those incarcerated.

GOVERNMENT

The South Carolina STD/HIV Program was run by an acting director for several months in 2007-08 and was affected by a lengthy restructuring process. In 2007 the state drew national attention as its ADAP program generated a waiting list, which reached 500 individuals at one point before being eliminated through a \$3 million supplemental appropriation from the state legislature. The new Ryan White distribution formula for federal monies also partially alleviated the situation.

However, the HIV program is more reliant than ever on federal money.⁷⁵ In the words of one official, 'A large group [of HIV patients] is falling between the cracks.' Some research studies are enrolling individuals needing medications and easing the strain on state resources.

The state Community Planning Group, now known as the HIV Planning Council, recognized the emerg-

71. Stan Stolarczyk, ACCESS Network, personal communication, July 2007.

72. Mary Basil, Beaufort-Jasper-Hampton Comprehensive Care Center, personal communication, July 2007.

73. Tony Price, South Carolina Roundtable presentation June 4, 2008.

74. Tony Price, SC Department of Health and Environmental Control, SC Roundtable on Latinos and HIV/AIDS, June 4, 2008, Columbia.

75. Susan Fulmer, SC Department of Health and Environmental Control, personal communication, July 2007.



ing epidemic among Latinos in South Carolina in its 2004-2008 prevention plan. The 2010-14 prevention plan is expected to address the problem of HIV-positive residents who are not currently benefiting from modern treatment and care in addition to prevention issues.

The state's Commission for Minority Affairs established a Hispanic/Latino Ad Hoc Committee in 2000 that included some 50 members and issued an advisory report after a year of meetings.

CURRENT CONDITIONS

For general health care, Volunteers in Medicine in Hilton Head provides an example of a safety-net clinic serving the low-wage uninsured. It has an active patient roster of 6,000 of whom 59 percent are Latino. It employs a dozen full-time staff to manage 250 volunteer health professionals drawn from the large retiree population.

In a neighboring county the federally-funded Beaufort-Jasper-Hampton Comprehensive Health Center serves some 19,000 registered patients annually at eight sites. Hispanics comprise 28 percent of its patient population.

There is also a summer satellite clinic on St. Helena Island for seasonal labor on the tomato farms. The St. Helena clinic has not detected any HIV cases although testing is fairly routine there.

Dr. Wayne A. Duffus of the University of South Carolina studied the frequency of doctor visits by individuals with undetected HIV infection in the state who are not tested for the virus at that time of the visit, so-called 'missed opportunities' for case detection. The frequency of late testers (individuals diagnosed with AIDS within one year of first testing positive for HIV) is an important obstacle to reducing the burden of disease and slowing the rate of new infections. Dr. Duffus noted that only 3 percent of the South Carolina emergency rooms surveyed routinely conducted HIV tests. Emergency rooms are used frequently by Latino residents.

Care for HIV-positive Latino clients is keeping up with demand, but bilingual and/or bicultural employees remain scarce in the state. When AIDS service organizations are linked to the primary care services used by Hispanic residents, testing and referrals proceed smoothly.



Prevention education for Spanish-speaking residents is sporadic and may have wound down entirely in the Columbia area after the suspension of Latino outreach and screening in 2007. An ad hoc ‘AIDS 101’ presentation at the Hilton Head hiring hall in June 2007 was the first of its kind for all those present although some of the men knew about HIV and condom use from their home countries.

All pregnant women are tested for HIV for free if they use public family planning clinics, and some male partners also agree to the test at that time.

Church charities are a key point of access to the immigrant community. Holy Family Catholic Church in Hilton Head is a typical case for large Latino congregations: it holds an annual health fair in January with all local voluntary organizations to provide basic screenings and information.

A primary care clinic in Columbia serving Hispanic clients recently obtained a grant to add HIV work to its mandate. Meanwhile, an ongoing research study undertaken through the University of South Carolina will examine HIV testing experiences from the perspective

of both pregnant Latina women and prenatal care providers in the state.

A Latino organization based in Columbia has experience in the issue and carried out extensive HIV testing in the area in conjunction with the VOICES/VOCES intervention.

The South Carolina Hispanic/Latino Health Coalition grew out of the work of the Task Force on Hispanic Issues formed by Governor Jim Hodges in 2000. The chair of the health subcommittee of that panel then formed the Coalition in 2002 to continue to advocate for Latino health and quality healthcare services in South Carolina.

The state health department continues actively to seek opportunities to screen for HIV among the Latino population. In some areas staff visit weekend soccer games using a mobile van and target other activities where Latinos congregate. Factories that employ large numbers of Hispanic workers occasionally provide access for HIV screening. The health department has established a liaison with three Columbia hospital emergency rooms to respond to the testing demands and handle referrals.⁷⁶

76. Duffus WA (2006) ‘Missed Opportunities for Earlier Diagnosis of HIV Infection—South Carolina, 1997-2005,’ *MMWR* 55(47):1269-72.



SOUTH CAROLINA ROUNDTABLE

The Commission convened a Roundtable on Latinos in South Carolina and HIV/AIDS on June 4, 2008, with the invaluable assistance of local partners from three CBOs and the University of South Carolina. Thirty individuals from AIDS service organizations and other private and public entities joined the meeting from five urban areas throughout the state.

Attendees heard summaries of current conditions in the state from representatives of the state health department, academic researchers, providers and advocates. Their recommendations included a call to return to disaggregated data reporting on Latinos (rather than combining Latino clients with a broader category of ‘others’), increased Latino representation on the HIV Planning Council, and expanded service hours to accommodate this population.

The state also created a Working Group on Latino issues in the HIV Planning Council as an outcome of the Roundtable, which is now chaired by a member of the Roundtable organizing committee.

CHURCHES ARE A CRUCIAL MEETING POINT FOR LATINO NEWCOMERS AND OFTEN JOIN HEALTH-PROMOTION ACTIVITIES.





TENNESSEE

Table 26: **Demographic and epidemiological facts:**

Estimated 2007 state population (ACS):	6,157,000
Estimated 2007 Latino population (ACS)	217,000 (3.44%)
Reported HIV/AIDS cases (12/31/06)	20,289

Table 27: **Tennessee reported overall and Latino HIV diagnoses, 2005-2007**

Year	HIV diagnoses	Latino HIV diag.*	Others % of total
2005	1003	40	3.99%
2006	1002	39	3.89%
2007	n/a	n/a	n/a

Source: Tennessee Department of Health, HIV/AIDS/STD Section, STD Data Surveillance Reports

Table 28: **Adult and Adolescent Annual AIDS Case Rate per 100,000 Population, by Race/Ethnicity, Reported in 2006, Tennessee**

Caucasian	African-American	Latino
5.2	54.5	20.5

Source: Kaiser Family Foundation, www.statehealthfacts.org

Table 29: **Rates per 100,000 population of total adults and adolescents living with HIV/AIDS in Tennessee at the end of 2006**

Caucasian	African-American	Latino
132.3	923.6	224.8

Source: CDC (2008) HIV/AIDS Surveillance Supplement Report 13(1): 39-40.



DEMOGRAPHICS AND IMMIGRATION

Tennessee and especially the capital, Nashville, is a new destination for Hispanics, and one in six residents of the city is now foreign-born⁷⁷. The Census Bureau and an independent academic study both place Nashville's Latino population at 40,000 to 50,000, or 7 percent of the city's total. Another estimated 25,000 Latinos reside in Memphis, Tennessee's second largest city. Many Latinos also live in the towns and cities adjacent to Memphis on the Arkansas and Mississippi sides of the border where housing is cheaper. Substantial Latino enclaves are scattered throughout the state near poultry plants and other areas of labor shortages.

Nashville enjoyed a booming economy during the last two decades and at one point was the fastest-growing housing market in the country. Jobs were plentiful although the manufacturing base, where employment includes health insurance benefits, is drying up. Immigrants work in casinos, services and poultry, cotton, soybeans and rice farms. Hispanic workers are also common in construction especially roofing jobs, gardening and tree harvesting.

Although the Hispanic population remains politically marginal since so many are not voting citizens, immigrants of many nationalities that have developed communal and religious organizations have united to combat city measures that would damage their well-being such as an 'English-only' law proposed in the Nashville City Council.

Nonetheless, the increasing resentment of the newcomers is palpable; two health professionals mentioned that their Spanish-speaking children feel ostracized and now speak only English in public. Policing for immigration purposes is also much more severe just in the last two years. Traffic stops are used to check for residency papers, and the main HIV care center in Nashville reports that it has lost patients who were picked up and deported with no opportunity to maintain their continuity of treatment.

HIV/AIDS

Reported cases of HIV among Latinos are substantial in Nashville while still low in Memphis. Over half of persons with HIV statewide are African-Americans although they comprise only 17 percent of the state popu-

77. Avi Poster, Coalition for Education about Immigration, email communication, Nov. 14, 2008.



lation.⁷⁸ Hispanics account for about 4 percent of notified cases statewide although providers suspect there are many more. Half of all HIV cases in the state are in Memphis where Chlamydia and syphilis rates remain among the highest in the nation.⁷⁹

New HIV cases peaked in 2001-02 and are currently approximately 1,000-1,100 per year. HIV services in Tennessee are structured to help clients with multiple challenges, and income eligibility requirements that are often so low as to exclude all but the poorest. Many clients earn less than \$10,000 per year.

CURRENT SERVICES

The Nashville-based Comprehensive Care Center (CCC) is the largest clinical care provider in the state, serving some 2200 individuals, and approximately 4 percent of the active patients are Latinos. The Center was formed to alleviate the growing pressure of new cases handled by the health department with assistance from Baptist Hospital and medical students on rotation from Vanderbilt University.

The CCC's first director, Drema Mace, also had been the state HIV/AIDS program director and saw the need for a set of standard HIV clinical protocols. In addition, the state of Tennessee created its own Medicaid program known as TennCare, which provided generous benefits for individuals with an HIV diagnosis. TennCare reimbursement enabled the CCC to become a 'one-stop' medical and auxiliary care provider. The CCC created a system of Centers of Excellence that set the standards for HIV care in Tennessee with the endorsement of the state health department.

However, the TennCare system came under attack and was finally abolished in 2005, leaving some 300,000 Tennesseans uninsured. After a period of serious financial stress, the CCC recovered aided by the new formula for distribution of Ryan White funds.

The CCC has a staff interpreter and other bilingual caregivers. It does case teleconferencing or videoconferencing several times a week to assist providers around the state including their three satellite clinics headed by nurse practitioners. Its Patient Assistance Program now covers medications for 180 clients.

78. Tennessee Department of Health HIV/AIDS/STD Program (2005) '2005 Tennessee Integrated Epidemiologic Profile for HIV/AIDS Prevention and Care Planning.'

79. Vincent Glover, Shelby County Department of Health, personal communication, December 2006.



The Davidson County/Nashville health department has set up primary clinics to accommodate non-English speakers in Hispanic neighborhoods. The county also enrolled 35,000 people in a program to reduce use of emergency rooms and to create a safety net for the uninsured.⁸⁰

In addition, the church-based First Response Center provides HIV-related services for a largely homeless population in Nashville. Another large HIV provider organization, Streetworks, directed by a former substance user, targets a similar population and recently added a fulltime Latina outreach worker. Nashville Cares also provides a wide range of non-clinical HIV services and now has two bilingual staff members.

Meharry Medical Center, a historically black college in Nashville, hosts a large HIV service and clinic for approximately 200 active clients on the grounds of the General Hospital. Meharry has bilingual providers including a staff psychologist, a rarity in Nashville. It is also responsible for care for all HIV-positive prisoners in the state. Some Hispanic patients reportedly have left treatment as a result of immigration-related fears or deportation.⁸¹

The main public hospital in Memphis serves some 1200 active patients. The non-profit Friends for Life, the main auxiliary service provider in Memphis, has 1600 clients in 17 counties and provides all non-clinical services as well as housing assistance through the Housing Opportunities for People with AIDS (HOPWA) Program.⁸²

Uninsured Latinos rely on safety-net providers for primary care. Christ Community, a faith-based, federally-funded clinic serving poor communities in Memphis, began HIV-related services in 2006. About 10 percent of its clients are Latino.⁸³

Tennessee's county health departments play a large role in direct delivery of care. Five counties directly administer an HIV/AIDS Center of Excellence, of which there are eleven around the state. Latinos clients including the undocumented can receive care in these centers although some programs are not available to them.

Prevention is lagging according to most informants while health fairs are often used to offer HIV screening. A few projects are funded by the Pfizer Southern AIDS Initiative, but most prevention support comes from federal monies distributed by the regional planning councils.

80. Frances Clark, Nashville-Davidson Department of Health, personal communication, December 2006.

81. Vladimir Berthaud, Meharry Medical College, personal communication, December 2006.

82. Ricci Hellman, Gina Fortner, Ana Miranda, Jamie Russell, Friends for Life group interview, December 2006.

83. Bert Waller, Nathan Cook, Christ Community Health Services, December 2006.



TENNESSEE LATINO HIV/AIDS STRATEGY MEETING

The Commission convened a meeting June 25, 2008 in Nashville in conjunction with the Division of Minority Health and Health Disparities Elimination of the Tennessee Department of Health (TDH). It was opened by Dr. Cherry Houston, Division Director, and Jeaneece Seals, Director of the HIV/AIDS/STD Section of the Department.

Fifty-six participants heard summaries of the present state of HIV/AIDS services targeting Latinos from two of the main Nashville HIV provider organizations, the Comprehensive Care Center and the Meharry Medical College. The rural perspective was provided by family nurse practitioner Lynn Schuster of the TDH Upper Cumberland Regional Office in Cookeville, about 75 miles east of the capital.

Recommendations that emerged from the meeting were influenced by a widespread observation among the group that Latinos in Tennessee avoided services, including HIV-related care, for fear of deportation. They urged a series of measures including the creation of a statewide coalition through the Tennessee Community Planning Group and further study of the feasibility of a new CBO explicitly dedicated to the issue of Latinos and HIV/AIDS. They also proposed universal screening of inmates for HIV in the state's jails and prisons.





SYNTHESIS OF RECOMMENDATIONS FROM SEVEN STATEWIDE FORUMS ON LATINOS AND HIV/AIDS

Although each state addressed a set of unique circumstances related to their Latino communities, many of the recommendations that emerged from the state meetings were similar. A summary of those most frequently mentioned follows:

(1) DATA/RESEARCH RECOMMENDATIONS

- Improve national, state and local surveillance data on the Latino population.
- Improve knowledge of intimate relationships in Latino cultures and on the Latino family unit in the new context of emerging immigrant communities.
- Monitor service delivery performance and satisfaction.
- Learn about HIV/AIDS prevention practices/campaigns in countries of origin.
- Integrate HIV prevention into other health and social services and programs.
- Address barriers to adherence and maintenance in care for Latino clients.

(2) OUTREACH & RECRUITMENT RECOMMENDATIONS

- Identify and map community resources.
- Increase ties with Hispanic religious leaders and faith communities.
- Create training modules in Spanish on DVD.
- Explore partnerships with worksites and employers.
- Identify successful outreach programs and replicate them.
- Recruit Latino volunteers, bilingual university students or other bilingual local residents.
- Identify possible ‘gatekeepers’ among small business owners, trailer parks, apartment complexes and soccer leagues.
- Forge links with Spanish-language media in the area.



(3) CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES RECOMMENDATIONS

- Adjust clinic hours to accommodate Latinos who work long hours and have no paid sick or administrative leave.
- Link CLAS (culturally linguistically appropriate services) improvements to national health disparities elimination.
- Find or create Spanish-language and limited-literacy materials.
- Research and formulate recommendations on phone interpreting services; obtain services for all commonly-used languages and dialects.
- Explore use of AmeriCorps Vista volunteers to serve as interpreters.
- Find ways to increase consumers' understanding of U.S. medical systems.
- Encourage students in the healthcare/social service professions to learn Spanish and explore innovative ways to support these efforts.

(4) NETWORKING RECOMMENDATIONS:

GOVERNMENT/DOH LEVEL:

- Create a working group within the state Planning Council.
- Partner with other states.
- Improve liaison with other screening programs.

CBO/AGENCY LEVEL:

- Develop a resource directory with information on: bilingual staff, interpreter availability and documentation requirements.
- Compile a resource guide for agencies to facilitate referrals.



(5) INTERVENTION

RECOMMENDATIONS:

- Research additional HIV care and prevention interventions for these mobile populations.
- Formalize ASO participation in the process of adaptation of existing interventions for Latinos and especially Latinos in the South.
- Partner with existing Latino organizations to carry out joint interventions.
- Expand intervention trainings.
- Utilize Spanish-language media.
- Capitalize on prenatal and STD clinic settings as possible prevention implementation sites.

(6) POLICY

RECOMMENDATIONS

- Raise the need to recruit and retain bilingual staff with health departments and state legislatures.
- Improve opportunities for immigrants and children of immigrants to become healthcare/social service professionals.
- Expand Medicaid prenatal coverage to undocumented women.
- Establish one-stop information sites for immigrants.
- Improve benefits for HIV/AIDS social workers.
- Increase Latino representation on HIV Planning Councils or Community Planning Groups.





RECOMMENDATIONS FROM THE LATINO COMMISSION ON AIDS

(1) EMERGING LATINO COMMUNITIES IN THE SOUTH HAVE URGENT HEALTH PROMOTION AND CARE ACCESS NEEDS, INCLUDING SERVICES RELATED TO HIV/AIDS, THAT ARE NOT BEING MET. ACTIONS ARE NEEDED IN BOTH THE PUBLIC AND PRIVATE SPHERE TO ADDRESS THESE SHORTCOMINGS, INCLUDING BUT NOT LIMITED TO THE FOLLOWING:

- (a) Health departments should conduct an in-depth community mapping in conjunction with local leaders to assess the specific needs of Latino communities related to HIV/AIDS.
- (b) Subsequently, health departments should assess their workforce to determine its level of preparation for

servicing all communities and should initiate a dialogue with Latino communities about existing resources and needs.

(c) Provider groups, together with local partners, should develop outreach and care plans that will work with the Latino population even in the absence of Spanish-speaking staff.

(d) Actions to improve HIV/AIDS services should be closely linked to the Latino population's efforts to address all its health needs, including primary care, prenatal and specialty services, other preventive and health-promoting efforts, and access to urgent care.

(e) Agencies in areas with significant Latino populations should be supported to improve the linguistic and cultural competency of their services.

(f) HIV testing should be made routine among Latino immigrants and combined with guarantees of privacy, comprehensive care for those found to be HIV-positive and sustained prevention education strategies.



(g) Given the disproportionate presence of gay Latinos and other Latino men who have sex with men in the HIV/AIDS statistics, health departments should gather relevant data on these populations and present the findings to their Community Planning Groups to formulate recommendations for action.

(h) Health departments, provider groups and academic partners should investigate the commercial sex industry to determine how best to address the vulnerabilities of sex workers and the men who use these services.

(2) REGIONAL COOPERATION SHOULD BE STRENGTHENED TO MAXIMIZE THE IMPACT OF SUCCESSFUL INNOVATION, SHARE RESOURCES AND BUILD DYNAMIC, COOPERATIVE PARTNERSHIPS FOR IMPROVED PERFORMANCE AND OUTCOMES.

(a) Because providers and advocates in the South doubt that available epidemiological data accurately reflect the state of the HIV epidemic among Latinos, initiatives are needed to improve data collection and to stan-

dardize reporting of racial and ethnic characteristics throughout the southern region.

(b) Information about successful outreach and prevention education strategies targeting Latino populations should be shared more broadly in the region so that these programs can be replicated.

(c) Agencies, advocates and health departments should articulate the public health rationale for providing preventive and curative services to all those who need them and should combat measures to exclude immigrants from needed services as undermining the health of the entire community.

(d) On the eve of the 2010 census, academic institutions in the seven states should initiate research on the health and well-being of their Spanish-speaking residents and partner actively with service providers to evaluate their performance.

(e) States should incorporate Latino issues into their formal HIV/AIDS planning and coordination structures, such as has been done in North Carolina through its Latino HIV/AIDS Initiative within the state Communicable Diseases Branch and in South Carolina through the creation of a Working Group on HIV/AIDS and Latinos in the state HIV Planning Council.



(f) States should reform credentialing and licensing requirements so that Spanish-speaking professionals trained outside the country can practice and begin to reduce the huge shortage of bilingual health educators, social workers and other health-related positions in the South.

(g) States and counties should replicate safety-net primary care models for uninsured Latino residents that build on existing community resources such as faith communities' social service arms and assist them in incorporating HIV/AIDS/STD programs into their operations.

(3) THE RAPIDLY EXPANDING SPANISH-LANGUAGE PRINT AND BROADCAST MEDIA IN THE SOUTH SHOULD BE ENCOURAGED TO EMBRACE A PREVENTION-BASED, HEALTH-PROMOTING APPROACH TO THE MEDICAL AND HEALTH NEEDS OF THE HISPANIC COMMUNITY THROUGH CONSISTENT DISSEMINATION OF RELIABLE HEALTH INFORMATION.

4) PROVIDE SPANISH-SPEAKING FAITH COMMUNITIES WITH TRAINING, RESOURCES AND ASSISTANCE ON HEALTH PROMOTION AND HIV PREVENTION STRATEGIES.

5) INVEST IN HEALTH LEADERSHIP BY LATINO ADVOCATES.



MOLDEANDO UNA NUEVA RESPUESTA: VIH/SIDA & LATINOS EN EL SUR DE LOS ESTADOS UNIDOS

RESUMEN EJECUTIVO

A través de un programa de dos años en búsqueda de datos y cooperación facilitado por la Comisión Latina sobre el SIDA en siete Estados del Sur de los Estados Unidos (Carolina del Norte, Carolina del Sur, Georgia, Louisiana, Mississippi, Tennessee y Alabama), se encontró evidencia de que las comunidades Latinas se están infectando con VIH en tasas desproporcionales a su representación poblacional y de que hay una tendencia de crecimiento acelerada con esta epidemia. Aunque los nuevos diagnósticos de VIH en la población Afro-Americana son las más altas en estos Estados del Sur, la tasa de infección entre Latinos son substancialmente significativas en comparación con la población Blanca-no Hispana; a la misma vez los mensajes de prevención y educación solo alcanzan esporádicamente a la población Hispana.

Se estima que 2 millones de residentes Latinos en los siete Estados cubiertos en el programa de la Comisión Latina sobre el SIDA “Latinos en el Sur del Sur” enfrentan limitaciones severas en cuanto al acceso a la atención médica de cualquier tipo, un obstáculo mayor para acceder los esfuerzos de atención médica y prevención relacionada al VIH/SIDA.

Mientras los inmigrantes enfrentan discriminación en sus vidas diarias, algunos Estados están diseñando restricciones para excluir a estas comunidades de recibir servicios gubernamentales, en vez de incorporar a estas nuevas comunidades Latinas en sus esfuerzos de promoción de salud pública en respuesta a sus necesidades y vulnerabilidades específicas.

Las Organizaciones trabajando en prevención del SIDA existentes y los Departamentos de Salud Pública se encuentran forzados ante una severa y limitada fuerza laboral bilingüe y bicultural de profesionales de la salud en esta región. A pesar del aumento de la infección del VIH en estos Estados del Sur, muchas personas no se dan cuenta de su estatus positivo al VIH, hasta que están muy enfermos y esto limita su capacidad de beneficiarse de una forma completa con los tratamientos disponibles hoy en día.

Las conclusiones principales en los dos años de investigación fueron:

- A través de la región, la infección por VIH y los casos de SIDA están creciendo con una tasa alarmante entre poblaciones Latinas, mientras la prevención y la educación están rezagadas. El acceso a



los servicios médicos relacionados al VIH se complican por el miedo, el estigma -y para la población indocumentada- con una variedad de obstáculos administrativos, prácticos y legales.

- Latinos y Latinas suelen descubrir que son positivos al VIH en un estado avanzado de la enfermedad o a través de una enfermedad seria o de un examen prenatal.
- Muchos Latinos en el Sur, especialmente los nuevos inmigrantes, no tienen acceso a atención médica y no son alcanzados por las actividades de promoción de la salud.
- Las Organizaciones de servicios y de prevención del SIDA en toda la región están haciendo esfuerzos para establecer contactos con las comunidades Latinas, a pesar de no contar en todos los casos con empleados bilingües.
- Los altos niveles de transitoriedad entre comunidades latinas inmigrantes, complica la implementación de iniciativas tradicionales de prevención de VIH con base en el alcance educativo entre pares o de igual a igual.
- El visible incremento del sentimiento antimigrante conlleva a que los Latinos desconfíen de los proveedores de servicios médicos y los Departamentos de Salud, debilitando las campañas de promoción de salud pública.
- Aunque la atención médica para aquellos infectados con VIH se encuentra regularmente disponible, aquellos indocumentados enfrentan obstáculos adicionales para poder manejar su enfermedad.

- La falta de empleados profesionales bilingües entrenados, limita las iniciativas de prevención y el poder llevar servicios médicos; los pocos trabajadores bilingües de campo están sobre saturados y se espera que cumplan múltiples funciones.
- Una industria próspera y muy organizada es la del sexo comercial, que genera un ambiente de alto riesgo tanto para los hombres inmigrantes, como para aquellos y aquellas que trabajan proveyendo servicios sexuales.
- La alta tasa de nacimientos entre Latinos ha llevado a aumento acelerado de hispanoparlantes en las escuelas públicas. Esta realidad llama a que se desarrollen programas tanto para los padres como para sus adolescentes en toda la región.
- Intervenciones diseñadas para hombres Gay Latinos o para hombres que tienen sexo con otros hombres son escasas en los Estados del Sur.

Todos estos temas son tratados en detalle a continuación. Después de los resúmenes de las realidades de cada Estado, se presenta una síntesis de las recomendaciones y pasos a seguir, que resultaron de las siete reuniones estatales convocadas como parte de este proyecto investigativo. Concluiremos este resumen ejecutivo con las recomendaciones propias de la Comisión Latina sobre el SIDA acerca de cómo responder a los retos relacionados al VIH/SIDA en esta región del país.



SINTESIS DE LAS RECOMENDACIONES DE LOS SIETE FOROS ESTATALES SOBRE LATINOS/AS Y EL VIH/SIDA

A pesar que cada Estado abordó circunstancias únicas relacionadas a sus respectivas comunidades Latinas, muchas de las recomendaciones que surgieron de las reuniones Estatales fueron similares. Un resumen de las recomendaciones relacionadas al VIH/SIDA que fueron mencionadas más frecuentemente se detalla a continuación:

- Integrar recomendaciones en la investigación a través de entrevistas con individuos claves en la comunidad.
- Integrar la prevención del VIH en otros programas y servicios sociales.
- Identificar barreras para mantenerse en tratamiento y atención médica a clientes Latinos.

(1) RECOMENDACIÓN EN LA RECOLECCIÓN DE DATOS E INVESTIGACIÓN

- Mejorar la vigilancia/recolección de datos nacionales, Estatales y locales sobre la población Latina.
- Mejorar el conocimiento sobre las relaciones íntimas en la cultura Latina y sobre la unidad familiar Latina en el nuevo contexto de las emergentes comunidades inmigrantes.
- Monitorear el rendimiento y la satisfacción acerca de los servicios en las comunidades Latinas que reciben servicios de VIH/SIDA.
- Aprender sobre las prácticas preventivas relacionadas al VIH/SIDA y las campañas de sus países de origen.

(2) RECOMENDACIONES PARA EL ALCANCE COMUNITARIO Y EL RECLUTAMIENTO

- Identificar recursos a través de mapeo de la comunidad.
- Incrementar los lazos con liderazgo religioso hispano y comunidades de fe.
- Crear módulos de entrenamiento en español en DVD.
- Explorar cooperaciones con lugares de trabajo y con empleadores.
- Identificar estrategias exitosas de alcance comunitario y replicarlas.
- Reclutar voluntarios Latinos, estudiantes bilingües universitarios, así como residentes locales bilingües.
- Identificar posible “Ciudadanos claves” entre dueños



de pequeño negocios, áreas designadas para casas móviles, edificios de vivienda y ligas de fútbol.

- Forjar vínculos con los medios de comunicación en español en cada área.

(3) RECOMENDACIONES SOBRE SERVICIOS LINGÜÍSTICA Y CULTURALMENTE ADECUADOS PARA LAS COMUNIDADES LATINAS.

- Ajustar los horarios de las clínicas para acomodar a los Latinos, quienes trabajan largas horas ya que no cuentan con días de enfermedad pagados o permisos administrativos de salida en horas hábiles.
- Vincularse al mejoramiento de Servicios Apropriadados Lingüística y Culturalmente, conocidos por sus siglas en Ingles, CLAS para la eliminación en las disparidades de salud a nivel nacional.
- Encontrar o crear materiales en español o para personas que carecen de alfabetización.
- Investigar y formular recomendaciones sobre servicios de interpretación telefónica para obtener servicios en lenguajes y dialectos utilizados comúnmente.
- Explorar el uso de voluntarios de AmeriCorps Vista para que sirvan como interpretes.

- Encontrar maneras para incrementar el entendimiento de los Latinos sobre el sistema medico de los Estados Unidos.
- Motivar para que estudiantes en el campo de salud y servicios sociales estudien español y exploren maneras innovadoras para apoyar estos esfuerzos.

(4) RECOMENDACIONES SOBRE EL DESARROLLO DE REDES DE COOPERACIÓN.

Gobierno/Departamento de Salud

- Crear grupos de trabajo dentro del Consejo de Planificación Estatal del VIH.
- Asociarse con otros Estados para colaborar en este esfuerzo.
- Mejorar vínculos con otros programas de detección de enfermedades transmisibles.

Organizaciones comunitarias/Agencias de servicios

- Desarrollar un directorio de recursos con información sobre: Personal bilingüe, disponibilidad de intérpretes y documentación requerida para obtener servicios.
- Copilar una guía de recursos de las agencias para facilitar hacer referidos de servicios.



(5) RECOMENDACIONES SOBRE INTERVENCIONES DE PREVENCIÓN

- Investigar intervenciones de prevención y atención relacionada al VIH para esta población móvil.
- Formalizar la participación de Organizaciones de Servicios relacionados al SIDA (ASO por sus siglas en Ingles) para su participación en el proceso de adaptación de intervenciones efectivas existentes para Latinos y especialmente para Latinos en el Sur
- Asociarse con organizaciones Latinas existentes para implementar intervenciones relacionadas al VIH.
- Ampliar capacitación sobre las intervenciones de VIH ya existentes.
- Utilizar medios de prensa en español.
- Capitalizar aquellos lugares de servicios prenatales y clínicas de Enfermedades de Transmisión Sexual, conocidas por sus siglas en Ingles, STD como posibles lugares para implementar intervenciones de prevención del VIH.

(6) RECOMENDACIONES SOBRE POLÍTICAS PÚBLICAS

- Presentar la necesidad de reclutar y retener personal bilingüe en los departamentos de salud y en las legislaturas estatales.
- Mejorar las oportunidades para inmigrantes e hijos de inmigrantes para que se conviertan en profesionales en el campo de la salud/servicios sociales.
- Ampliar los servicios prenatales de Medicaid para las mujeres indocumentadas.
- Establecer centros de información completa para inmigrantes.
- Mejorar los beneficios para los trabajadores sociales relacionados al VIH/SIDA.
- Incrementar la representación de Latinos en los Consejos de Planificación de VIH o Grupos de Planificación comunitaria Estatal de VIH.



RECOMENDACIONES DE LA COMISION LATINA SOBRE EL SIDA

(1) LAS COMUNIDADES LATINAS EN LOS ESTADOS SUREÑOS TIENEN GRANDES NECESIDADES DE PROMOCIÓN DE LA SALUD Y NECESIDADES DE ACCESO A LA SALUD, INCLUYENDO SERVICIOS RELACIONADOS AL VIH/SIDA, QUE NO ESTÁN SIENDO CUBIERTOS ACTUALMENTE. MUCHAS ACCIONES SON NECESARIAS TANTO EN LAS ESFERAS DEL SECTOR PÚBLICO COMO PRIVADO PARA TRATAR ESTOS VACÍOS Y RETOS. PRESENTAMOS UNA SERIE DE RECOMENDACIONES CON EL OBJETIVO DE CONTRIBUIR JUNTOS A RESPONDER A ESTA REALIDAD:

- Los departamentos de salud deberían llevar a cabo una investigación profunda de la comunidad en conjunto con líderes locales para evaluar las necesidades específicas de las comunidades latinas relacionadas al VIH/SIDA.
- Subsecuentemente, los Departamentos de salud, deberían evaluar su fuerza laboral para determinar su nivel de preparación para poder servir todas las comunidades y deberían iniciar un dialogo con las comunidades Latinas sobre recursos existentes y sus necesidades.
- Grupo de proveedores, junto a socios locales, deberían desarrollar planes de alcance y atención a las comunidades Latinas, a pesar de no contar con el personal que hable español.
- Las acciones para mejorar los servicios de VIH/SIDA deberían estar vinculados a los esfuerzos de la comunidad Latina para abordar todas las necesidades relacionadas a la salud, incluyendo atención médica primaria, servicios prenatales y servicios especializados, así como servicios preventivos, de promoción de salud y atención de emergencia.
- Las Agencias localizadas en áreas con población Latina significativa deberían ser apoyadas para que mejoren sus servicios lingüístico y culturalmente competentes.
- La prueba del VIH debería hacerse de forma rutinaria entre las comunidades inmigrantes, combinándolas con garantías de privacidad, integrales en servicios de atención medica para aquellos que den positivo a la prueba y sosteniendo estrategias preventivas.
- Dado la desproporcionada presencia de Latinos Gay y otros hombres que tienen sexo con otros hombres



en las estadísticas de VIH/SIDA, los Departamentos de Salud deberían juntar los datos relevantes sobre esta población y presentar sus conclusiones para que los grupos de planificación Estatal puedan formular recomendaciones para que se tomen acciones concretas.

- Departamentos de Salud, grupo de proveedores junto con socios académicos deberían investigar la industria comercial de sexo, para determinar como sería la mejor forma para tratar las vulnerabilidades de los/las trabajadoras sexuales y la población que usa estos servicios.

(2) COOPERACION REGIONAL DEBE SER FORTALECIDA PARA MAXIMIZAR EL IMPACTO DE EXITOS INNOVADORES, COMPARTIR RECURSOS Y CONSTRUIR UNA DINAMICA DE COOPERACION ASOCIATIVA PARA MEJORAR RENDIMIENTOS Y RESULTADOS.

- Esto se debe a que proveedores y defensores en los Estados del Sur tienen dudas acerca de que los datos epidemiológicos existentes reflejen exactamente el estado de la epidemia del VIH entre la población Latina. Urgen iniciativas en el campo de colección de datos necesarios para mejorar y estandarizar el reporte de características raciales y étnicas a través

de toda la región del sur de los Estados Unidos.

- La información disponible acerca de estrategias exitosas en el campo de prevención y educación dirigidas a poblaciones Latinas deberían ser compartidas más ampliamente en la región para que estos programas puedan ser replicados.
- Agencias, abogados/defensores y Departamentos de Salud deberían articular la argumentación necesaria desde la perspectiva de salud pública, sobre la importancia de proveer servicios de prevención y atención para todos aquellos que los necesiten y deberían combatir las medidas que excluyen a inmigrantes de servicios claves y muy necesarios, ya que el no proveerlos solo pone en riesgo la salud de la comunidad en general.
- En la ante sala al Censo 2010, instituciones académicas en los siete Estados podrían iniciar investigaciones sobre la salud y el bienestar de la población hispano parlantes en asociación activa con proveedores de servicios para evaluar su rendimiento e impacto de los servicios proveídos a estas poblaciones.
- Los Estados deberían incorporar los temas Latino en sus estructuras formales de coordinación y planificación relacionadas al VIH/SIDA, como lo han hecho Carolina del Norte con su iniciativa Latina de VIH/SIDA dentro de su Estructura Estatal y Carolina del Sur a través de la creación de un grupo de trabajo Latino y el VIH/SIDA en su Consejo de Planificación del VIH Estatal.
- Los Estados deberían reformar sus requerimientos



sobre credenciales y licencias para que profesionales que hablen español y que hayan sido entrenados en sus países, puedan contribuir a reducir la gran limitación de educadores de la salud, trabajadores sociales y otras posiciones relacionadas a la salud en los Estados del Sur.

- Los Estados y Condados deberían replicar modelos de redes de protección primaria en la atención para los Latinos que carecen de seguro médico, construyendo sobre recursos ya existentes como son los servicios sociales de las comunidades de Fe, asisténdoles para que incorporen programas de VIH/SIDA/ETS en sus operaciones ya existentes.

(3) LOS MEDIOS DE PRENSA ESCRITA Y TELEVISIVA SE EXPANDEN RÁPIDAMENTE EN EL SUR. SE DEBE PROMOVER QUE ESTOS MEDIOS TOME UN PAPEL PROTAGÓNICO EN LA DIFUSIÓN DE MENSAJES DE PREVENCIÓN, PROMOCIÓN DE SALUD Y LAS NECESIDADES DE LA COMUNIDAD HISPANA RELACIONADAS A ESTOS TEMAS A TRAVÉS DE LA DISEMINACIÓN CONSISTENTE DE INFORMACIÓN SOLIDARIDAD RELACIONADA A LA SALUD.

(4) PROVEER A LAS COMUNIDADES DE FE HISPANO-PARLAN- TES CON EL ADIESTRAMIENTO, APOYO TÉCNICO Y LOS RECURSOS NECESARIOS PARA PROMOVER LA SALUD Y LLEVAR A CABO ESTRATEGIAS DE PREVENCIÓN DEL VIH/SIDA.

(5) INVERTIR EN EL LIDERAZGO SOBRE TEMAS DE SALUD PARA DIRIGENTES COMUNITARIOS LATINOS.

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THROUGH THE “DEEP SOUTH PROJECT,” ACTIVE IN SEVEN SOUTHERN STATES (NORTH CAROLINA, SOUTH CAROLINA, GEORGIA, ALABAMA, MISSISSIPPI, TENNESSEE AND LOUISIANA), THE COMMISSION INVESTIGATED CURRENT CONDITIONS IN THE AREA TO CATALYZE NEW ASSESSMENT AND PLANNING INITIATIVES IN EACH STATE. OVER 300 SERVICE PROVIDERS AND CLINICIANS, HEALTH DEPARTMENT STAFF, ADVOCATES, ACADEMICS, JOURNALISTS, CLERGY AND COMMUNITY ORGANIZERS WERE INTERVIEWED. THE COMMISSION THEN CO-SPONSORED SEVEN STATEWIDE ROUNDTABLES ON HIV/AIDS PREVENTION AND CARE SERVICES REACHING LATINOS AND CONVENED A FOLLOW-UP MEETING IN ALABAMA THAT BROUGHT TOGETHER RESEARCHERS, STUDENTS AND PROVIDERS TO OUTLINE A RESEARCH AGENDA AND FORGE COOPERATIVE LINKS.



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