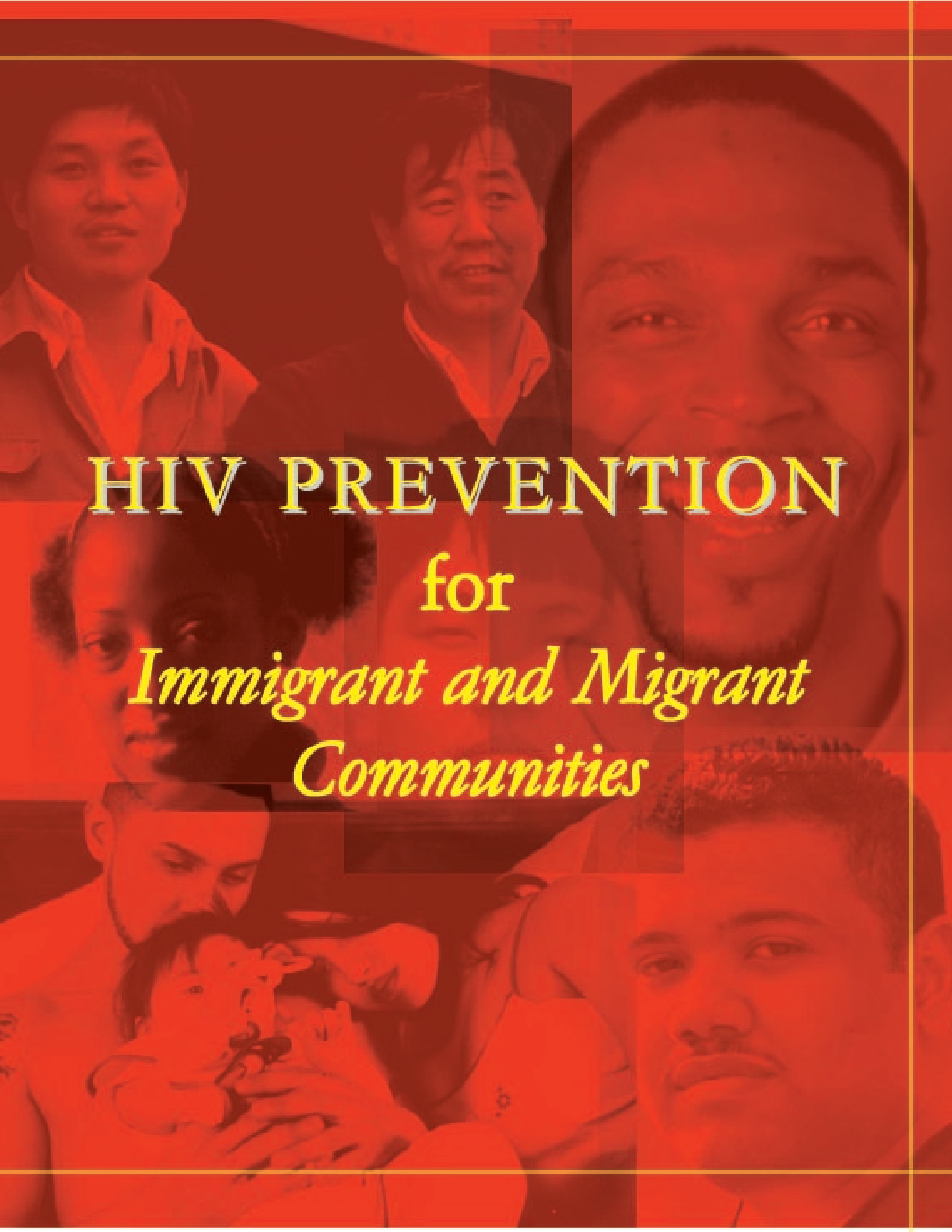

HIV PREVENTION for *Immigrant and Migrant Communities*

Table of Contents

ACKNOWLEDGMENTS

A report of this scope must be a collaborative effort, and this one truly is. Thanks go to the many individuals and organizations who participated in its creation, who were united by a desire to produce a document that would inform the larger community about the realities confronting New York State's diverse immigrant and migrant populations in their struggles with the AIDS pandemic.

Particular thanks go to everyone who helped organize the focus groups and write the results, including:

- Mei-Ching Chou and John Chin, Asian Pacific Islander Coalition on HIV/AIDS (Chinese Males and Females)
- Nineta Regalado and Julio Dicent, Alianza Dominicana [Dominican Females, Males and Men Who Have Sex With Men (MSMs)]
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- Wista Johnson and Joann Opustil, CAMBA; and Nathan Kerr, Community Marketing Concepts (Jamaican Males, Females and MSMs)
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- Andres Duque and Julia Andino, Latino Commission on AIDS (South American Females, Males and MSMs)

Thanks to the Partnership for Community Health (PCH), for assisting the Latino Commission in pulling together the wide range of information from the focus groups and provided a framework for understanding its significance. The members of the New York State HIV Prevention Planning Group deserve special thanks for their support and for urging the funding that enabled the completion of this project. The HIV Educational and Training Programs of the Office of the Medical Director (OMD) of the NYS Department of Health, AIDS Institute, has been extraordinarily supportive in resolving numerous difficulties that arose during the long duration of this contract. Finally, the report would not have been possible without the support and work of the staff of the Latino Commission on AIDS, especially Dennis DeLeon, Joann Casado, Julia Andino, Andres Duque, Marisol Arriaga and Guillermo Chacon.

INTRODUCTION

The Special Populations Research and Training Initiative on Immigrants and Migrants is intended to assist community HIV/AIDS educators in developing effective HIV prevention strategies which will overcome the barriers to prevention for New York's immigrant and migrant populations. This report, and subsequent training sessions, are intended to:

- Enable community HIV/AIDS educators and other HIV/AIDS service providers to deliver effective and culturally relevant approaches to building relationships with the immigrant and migrant populations in their catchment areas;

- Sensitize community HIV/AIDS educators and service providers to a variety of legal and social factors that prevent immigrants and migrants from seeking needed HIV/AIDS prevention services, both primary and secondary; and

- Familiarize community HIV/AIDS educators and service providers with models for delivering effective primary and secondary prevention services to migrant and immigrant populations.

The first part of this report -- **New York State's Immigrant Communities and HIV/AIDS –** reviews important epidemiological data regarding HIV seroprevalence among immigrants. Data regarding incidence of AIDS among immigrants in the US is provided.

The second part - **HIV Prevention and Immigrant Communities: The Research Report** – is intended to teach educators and providers how to build successful relationships with immigrant and migrant communities and to sensitize them to a variety of legal and social factors that prevent migrants from seeking prevention services. It reviews theories of behavior change in an effort to place HIV prevention services for immigrants and migrants into a larger theoretical framework. This section describes and summarizes the extensive research project that was undertaken by the Latino Commission. The recommendations in this part of the report are based on the demographic information compiled, as well as literature reviews and the results of 17 focus groups that were conducted among seven populations of immigrants and migrants. "25 Things You Can Do to Make Your Program Immigrant-Friendly" outlines practical steps for providers to establish better communication with immigrants in their programs. It is written in a colloquial style for ease of disseminating to all levels of employees in a variety of health and social services agency settings. The chapter entitled "Legal Realities Facing Immigrants" offers a basic overview of immigrant law and its social welfare implications.

The third part of this report - five Appendices - include: Summaries of a sample of the cultural overviews of the different migrant and immigrant communities who participated in this project; information about the prevalence of AIDS in foreign countries; tools of the focus groups, including Protocols, and Participant's Questionnaire; a list of Laws affecting HIV+ immigrants; and a Glossary of Important Immigration Terms.

EXECUTIVE SUMMARY

"HIV Prevention Services for Immigrant and Migrant Communities" reports in detail the design and results of seventeen focus groups conducted among immigrant and migrant populations throughout New York State over a period of late December, 1996 through the end of June, 1998. The report was prepared by the Latino Commission on AIDS and the following agencies assisted with recruiting participants, facilitating focus groups and interpreting the results: Finger Lakes Migrant Health Care Project, Partnership for Community Health, APICHA, Alianza Dominicana, Haitian Community Center, Hispanics United Buffalo (HUB), COLEGA, and CAMBA.

Four general patterns emerged from the focus groups:

- a diagnosis of HIV infection was viewed as stigmatizing, both within and outside all population communities, with fears ranging from "gay" labels to job loss and deportation;

- while youth tend to be more knowledgeable about HIV and AIDS, they are also more likely to engage in less-safe practices;

- among all groups, men who have sex with men (MSMs) were, generally, more informed about HIV; more likely to have engaged in testing and prevention activities; and more open to discussing sexual transmission of the virus.

- each community studied has unique qualities, strengths, challenges and opportunities; as such, service delivery must reflect an understanding and appreciation of the culture of each individual; one approach to accomplishing this is to hire persons from the community.

Highlights of information gleaned from the focus groups include:

- participants who knew people living with HIV or AIDS did not engage in fewer unsafe practices than others, but, rather, were more likely to rationalize their differences from those who are infected;

- awareness and knowledge about basic facts of HIV infection, routes of transmission and the progression to AIDS varied among participants; however, almost all participants reported that sexual intercourse without a condom with a casual sexual partner was a high-risk activity; most migrant seasonal farm workers were aware that HIV is transmitted through blood contamination and unprotected sex. However, folk traditions for all groups present a strong influence over self-protective behavior;

- negative attitudes about safer sex arose from the association of condoms with homosexuality, promiscuity and drug use;

- Dominican and South American MSMs, all Haitian groups and most migrant seasonal farm workers, recognize AIDS as a major problem in their communities, while heterosexual Dominicans view their risk for HIV to be too low to make testing a priority;

- television, newspapers and magazines tend to be major sources of information for many; however, migrant farm workers who are isolated in rural areas have little access to media, especially in their language; many participants said they did not read brochures or pamphlets;

- migrant farm workers are a "multi-ethnic" group influenced by the culture of their native countries and the "culture of migrancy"; migrant-specific health services are available throughout NYS in areas where many migrants work; effective messengers to this group include community health workers, physicians and the church; messages will be most effective when they are consistent and reinforced in all areas to which workers migrate.

Barriers to prevention include: time, transportation and financial limitations; language differences; unfamiliarity with the American health care system and the concept of preventive health care; feelings of powerlessness and a sense of fatalism regarding one's ability to affect personal health or social circumstances. In addition to the barriers experienced by immigrants in general, migrant farm workers experience numerous barriers specific to their life situation. Examples include the following- 1) migrant farm workers view preventive health care as a "luxury", 2) health issues only receive attention when they impair one's ability to work- in order to eat, one must work., 3) migrants, who often rely on employers for transportation, may be fearful of voicing concerns about health or seeking health services out of fear of being identified as "unhealthy" and thus losing their jobs.

Conclusions that can be gleaned from the focus groups include:

- Adequate counseling is a critical component of HIV testing; without counseling, HIV testing is ineffective as a prevention tool;

- Because the greatest attitudinal barrier is negative feelings about people who are living with HIV/AIDS, it is necessary to develop strategies that will remove the stigma of living with HIV infection or AIDS;

- Multi-lingual mass media campaigns can be an effective way to set a prevention agenda for immigrants and to a lesser extent migrants, as can the use of interpersonal networks, peer educators, and reinforcement of prevention through church organizations;

- AIDS service providers should sensitize staff to the needs of immigrants and migrants, particularly the need to treat immigrant and migrants with respect and to provide appropriate language services;

- Training should also sensitize staff to the fear of deportation experienced by many immigrants and the impact this fear may have on the willingness of immigrants to access HIV prevention, testing and care services;

- Changes in Medicaid and welfare laws restrict access to some, but not all, services; efforts should be made to ensure that staff clearly understand what services continue to be accessible to immigrants and migrant seasonal farm workers.

NEW YORK STATE'S IMMIGRANT COMMUNITIES AND HIV/AIDS

HIV SEROPREVALENCE AND IMMIGRATION

Epidemiological data of immigrant communities coping with HIV/AIDS is critical for providing answers to important questions about where prevention resources are most needed: should more resources be directed at immigrants who are recent arrivals, or at those who have been in the United States for some years? Are undocumented immigrants more vulnerable than those who have legal status? To what extent does HIV infection in home countries influence the likelihood of HIV infection in the United States? Which immigrants have the highest rates of HIV infection?

Presently, the only data collected about immigrants and HIV/AIDS are the cities and countries of birth for persons who have been diagnosed with AIDS. Information regarding immigration status at the time of diagnosis (all undocumented persons with AIDS are counted), including whether a person has naturalized to become a citizen or is still considered an immigrant by the Immigration and Naturalization Service, and the age at which individuals came to this country are not available. Additionally, there is no information gathered on immigrants who travel back and forth to their home countries or territories.

Nevertheless, we can learn a great deal about immigrants with AIDS from the information that is available about their countries of origin. The analysis that follows includes Puerto Rican persons with AIDS as well as individuals who were born in other U.S. territories, as persons from these regions share the immigrant experience in this country even though, as U.S. citizens, they do not require documentation in order to travel between their birthplaces and the 50 states.

I. IMMIGRANTS WITH AIDS IN THE UNITED STATES

- Sixteen percent (19, 782 people) of all reported AIDS cases in New York State in December, 1997, were among persons who were foreign-born.

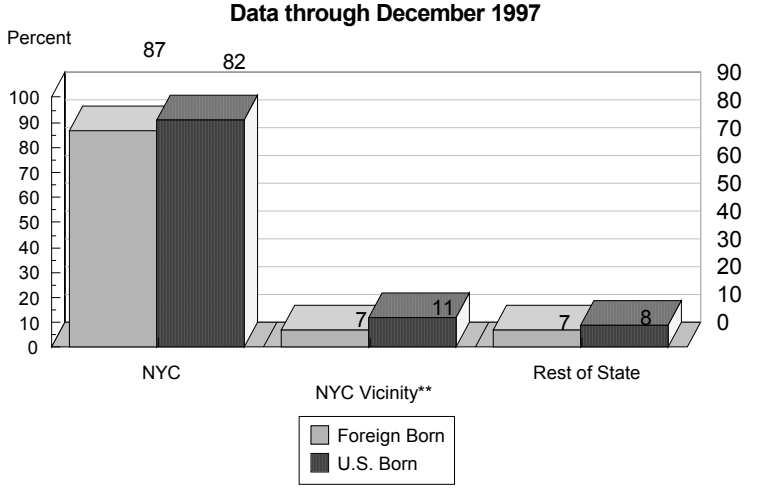
Cumulative New York State AIDS Cases
by Place of Birth
Data through December 1997

	Number	Percent
U.S.Born	79,821	65%
Foreign Born*	19,782	16%
Unknown	22,940	19%
Total	122,543	100%

Includes: residents of U.S. territories (Puerto Rico, U.S. Caribbean, U.S. Pacific Islands)

NYSDOH/BHAE - PPG 04/98

Cumulative AIDS Cases
Residence at Diagnosis by Place of Birth*
Data through December 1997



* Unknown not included
** Orange, Putnam, Rockland, Westchester, Nassau, Suffolk Counties

NYSDOH/BHAE - PPG 04/98

- Ninety-four percent of all AIDS cases reported among immigrants in New York State, and 93% of all AIDS cases reported among non-immigrants in New York State, have been reported in New York City and the surrounding counties.

Cumulative Number of Foreign Born AIDS Cases by Region of Birth
Data through December 1997

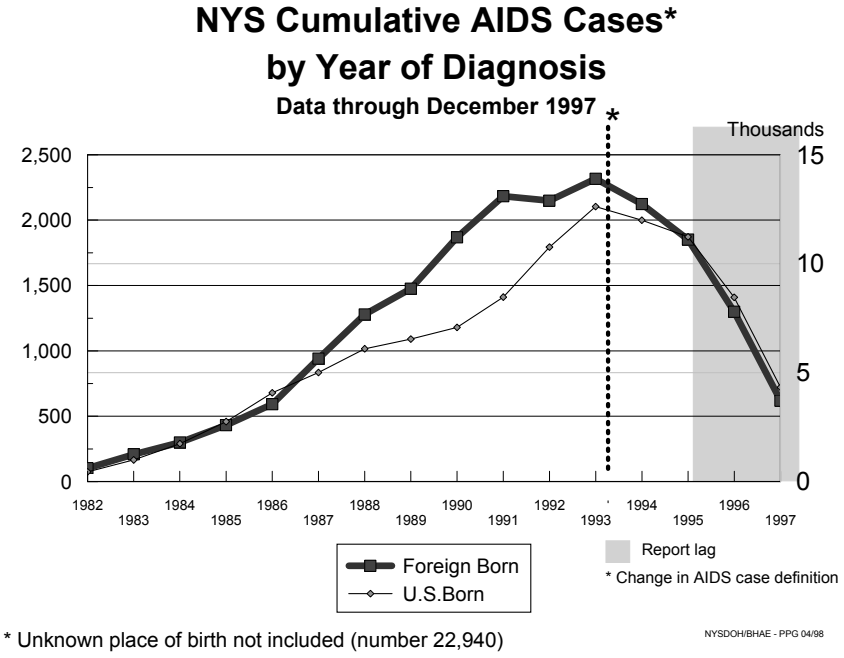
Caribbean	12739	Middle East	134
Central/S.America	2833	Canada	113
Europe	1147	U.S.Caribbean	111
Asia/Pacific	403	Oceania	43
Africa	296	U.S.Pacific Islands	2
		Unknown	1961
	Total	19,782	

NYSDOH/BHAE - PPG 04/98

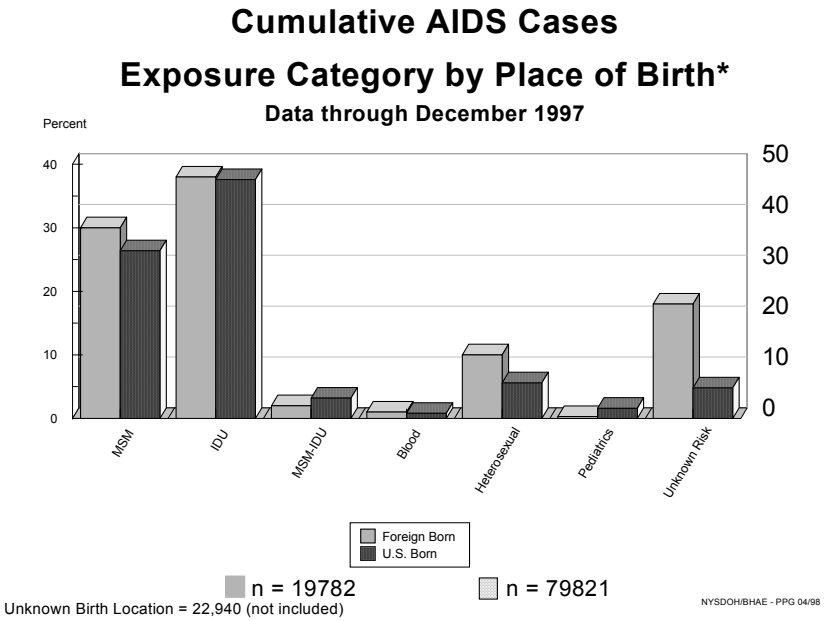
- The majority of immigrants with AIDS came from the Caribbean

- Sixty-two percent of the immigrants diagnosed with AIDS, for whom a country of origin was recorded, came from Spanish-speaking countries.

- While the total number of AIDS cases has sharply declined in general, the drop among immigrants has been more gradual.



- In ranking AIDS cases among immigrants by mode of transmission, approximately 40% are due to intravenous drug use; 30% are due to unprotected sex between male partners (MSMs); and 10% are due to unprotected heterosexual sex.



HIV PREVENTION AND IMMIGRANT COMMUNITIES: THE RESEARCH REPORT

I. THEORIES OF BEHAVIOR CHANGE APPLIED TO MIGRANTS AND IMMIGRANTS[1]

The theory underlying the design of this project is that there are varying pressures on migrant and immigrant groups that pull them toward, or push them away from, practices that make them vulnerable to HIV infection. Pressures that pull persons toward safer behaviors are directly related to AIDS prevention efforts. For example, understanding information about the consequences of HIV or information about safer drug use techniques, such as exchanging needles, can result in safer behaviors. Conversely, misinformation about HIV can push persons away from safer behavior. For example, the belief that only gay men, drug users or promiscuous persons contract HIV infection can push persons who do not identify with these communities away from safer behaviors.

Often, the reasons for adopting risk behaviors are not directly related to AIDS prevention information, but are found in the norms of the community. For example, the norm to have children can push persons toward unprotected sexual practices without any assessment of their risk for HIV infection. Similarly, the use of condoms for family planning can prevent pregnancy and can pull persons toward safer behaviors without an individual assessing their risk for HIV infection.

There is little evidence to quantify which factors are most important in pushing or pulling a migrant or immigrant toward safer behaviors. To obtain qualitative information, 17 focus groups among numerous migrant and immigrant populations were conducted under the supervision of the Latino Commission. To guide the discussion of what social, psychological and cultural factors lead to safer behaviors, the Partnership for Community Health (PCH) developed a focus-group protocol, which was to be used by the moderators of each of the focus groups (see Appendix B). As noted earlier, a questionnaire was also developed, which was to be completed by each focus group participant (see Appendix C).

The focus groups were designed to explore the informational, psychological, normative and structural factors that migrants and immigrants face in adopting safer practices. The specific factors related to adopting safer drug use and sexual behavior were based on four frameworks, discussed below. Relying on an extensive literature review, the frameworks propose several reasons why immigrants and migrants would be more likely to adopt or reject safer sexual and drug use practices.

[1]Several theories and models are discussed throughout this section. For specific studies and models, see the Bibliography at the end of this Report.

INFORMATION PROCESSING FRAMEWORK (Figure 1)

The most common HIV/AIDS prevention model is based on the belief that if individuals are informed about the serious consequences of HIV infection they will adopt or maintain safer sex and drug use practices. For immigrants and migrants, the objective of prevention efforts based on this model is to provide clear and culturally sensitive information to facilitate the decision-making process. Experience teaches that developing culturally sensitive material at appropriate readership, or viewing, level is itself a considerable challenge.

As shown in Figure 1 (see page 12), one reason for continuing unsafe practices is that migrants and immigrants are unaware, or are inadequately aware, of the serious health consequences of AIDS. Awareness makes up several parts of the prevention message. For example:

- Awareness of the consequences of HIV infection
- Awareness of safer sexual and drug-use practices
- Awareness of unsafe sexual and drug-use practices
- A positive attitude about safer sexual and drug-use practices
- Correct beliefs about the risk of safer and unsafe behaviors
- Accurate beliefs about risky practices.

The Information Framework suggests:

1.1 Awareness of serostatus through testing, particularly when combined with counseling, is positively related to increasing the perception of risk and the adoption of safer practices.

1.2 Awareness, attitudes and beliefs about safer and unsafe sex are related to sexual behavior, as shown below. A distinction is made between attitudes toward unsafe practices[2] and attitudes toward safer practices.[3] Research has indicated that persons can be very aware of safer practices and, at the same time, not very aware of unsafe practices and vice versa.

- Accurate beliefs about the relationship between unsafe practice and the transmission of HIV infection and progression to AIDS are positively related to adopting safer practices, and inaccurate beliefs about the relationship between unsafe practice and the transmission of HIV infection and progression to AIDS are negatively related to adopting safer practices.
- Positive attitudes toward safer practices, such as needle exchange, are positively related to the adoption of safer practices and negative attitudes toward safer practices are negatively related to adopting safer behaviors.
- Accurate beliefs about the relationship between safer practices and the transmission of HIV infection and progression to AIDS are positively related to adopting safer practices. Inaccurate beliefs about the relationship between safer practice and the transmission of HIV infection and progression to AIDS are negatively related to adopting safer practices.

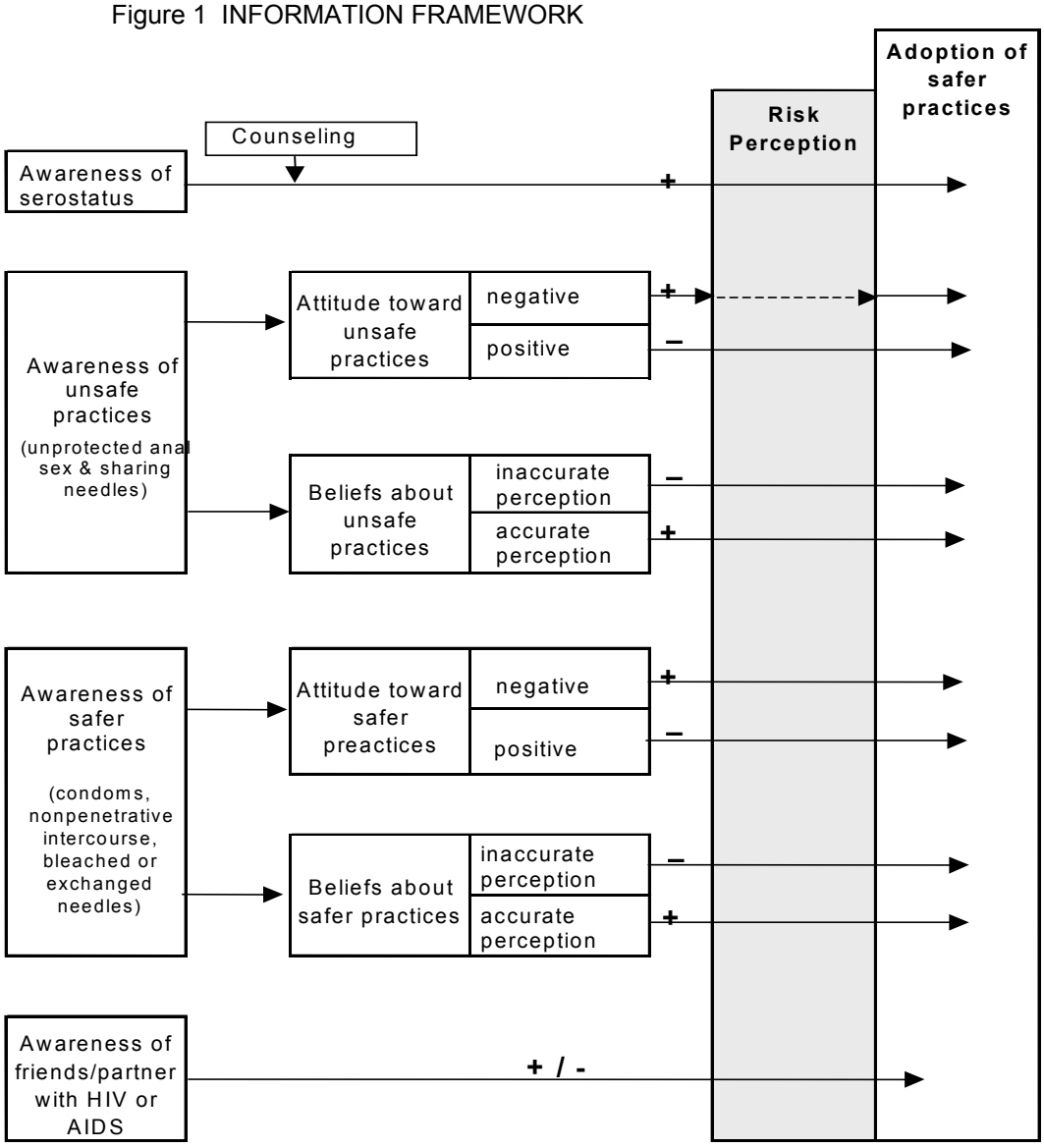
[2]For the purposes of this report, unsafe practices include unprotected sex with a monogamous partner and sharing needles.

[3]Safer practices refer to abstinence from sexual intercourse, sex with a mutually monogamous partner known to be HIV- , penetrative sexual intercourse with a condom, non-penetrative sexual intercourse and intravenous drug use with a clean needle or abstinence from drug use.

Awareness of friends and partners with HIV is likely to lead to heightened perception of risk and adoption of safer behavior, but it can also lead to a conclusion that "I'm not one of those (homosexuals, promiscuous people, injection drug users, etc.)" and, therefore, denial of risk and continuation of unsafe practices.

Figure 1. INFORMATION FRAMEWORK

Figure 1 INFORMATION FRAMEWORK



NORMATIVE FRAMEWORK (Figure 2)

The Normative Framework suggests that immigrants and migrants are influenced by interaction with their partners, peers and community, and the expected reactions of their peers and partners reinforce safer or unsafe practices.

Figure 2. NORMATIVE FRAMEWORK

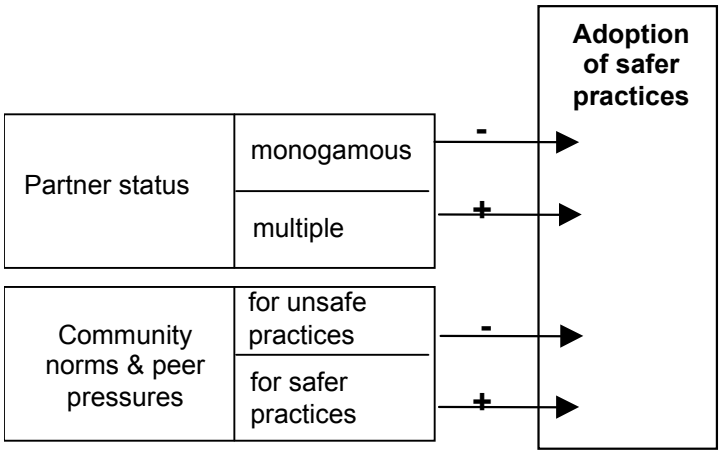


Table 1 shows that many HIV prevention messages run counter to some immigrant and migrant community norms. In the following sections, specific community norms related to each migrant and immigrant population are discussed. The values shown in Table 1 are found in several of the participating immigrant and migrant communities. For example, the desire to exchange body fluids can be an important ritual in the practice of sexual intercourse. HIV prevention messages recommend protected sex that limits this exchange and, consequently, they may face strong cultural opposition.

Table 1. CULTURAL vs. HIV PREVENTION MESSAGES

Cultural Norms	Prevention Message
Exchange of semen represents closeness, sensuousness, love.	No exchange of body fluids
Children are associated with valued attributes such as male potency and power, female fertility, and familial status.	Use a condom. The negative consequence for many is birth control and lack of desired children.
Children provide insurance for the family.	HIV-infected children are a burden on families and society.

Many immigrants and migrants carry strong religious beliefs. Those having other traditional beliefs, such as Voodoo, sometimes view AIDS as the result of a hex or spell placed on one person. For those who believe in these values, or feel they are judged by their peers, family and community who hold these beliefs, the prevention message of abstinence from high-risk behaviors or "stay faithful" may be effective.

Immigrants and migrants with peers or partners who strongly adhere to "Fundamentalist religious" values will find little support for AIDS prevention practices. Attribution[4] theory further suggests that persons may engage in risky practices because they expect their peers and partners to react negatively based on these religious values. For example, persons will not use condoms because they anticipate that their partners or peers will think doing so is a sign of infidelity or homosexuality.

On the other hand, when there is community support, and when safer sex becomes the normative behavior, there is a greater discussion of safer sex among peers and partners. The application of community norms that support safer practices, and the subsequent increased communication about safer practices, leads to a greater likelihood that safer practices will be adopted.

The media play a powerful role in reinforcing community norms and setting the agenda for what will be discussed between peers and partners. While there is little evidence that the media has the power to dictate practices, it can increase awareness and reinforce beliefs and attitudes that motivate persons to discuss safer practices or seek additional information.

Based on this framework, the following relationships are suggested:

2.1. Peer interaction and peer pressure

- When peers support safer behavior and it becomes the accepted norm, there is a positive relationship between peer pressure and safer practices.
- When peers do not support safer behavior and unsafe practices become the norm, there is a negative relationship between peer pressure and the adoption of safer practices.
- When peers talk about safer behavior, there tends to be more of it.

2.2 Partner interaction

- When partners are mutually monogamous and HIV negative, there are safer sexual practices.
- There is a positive relationship between the number of partners and adopting safer practices, but there is often greater risk[5]

2.3 Social groups

- When social groups such as churches, social and athletic clubs, and other groups actively support safer practices, there is a positive relationship between support and adoption of safer practices.

2.3 Media

- The more the media place safer behavior on the agenda of communities and advocate safer practices, the more likely they are to be adopted.

[4] Attribution theory suggests that persons adopt behaviors based on the expected reaction from others. *See* Heider, at p. 58; Fisk, Taylor, *et al.*, at p. 84; and Memon, at p. 91.

[5] The relationship is not causal. Persons can have multiple partners and engage in safer sex or have a single partner and engage in unsafe sex; it is the activity and not the number of partners that dictates safer behavior. Still, research has shown that persons with a larger number of partners tend to have more unsafe sex.

STRUCTURAL FRAMEWORK (Figure 3)

The third framework proposed consists of structural factors that are related to adopting safer practices. Structural factors are those factors outside the direct influence of the individual and embedded in the culture, laws or norms of the community. Table 3 displays some of the community values that are often in conflict with adopting safer practices.

Other structural factors include political and public policy support. These translate into needed resources for prevention efforts and raise the awareness of the need for prevention. In addition, rules and regulations regarding qualifications for entitlements can present barriers to testing and counseling among those who fear loss of confidentiality. Other structural factors include low literacy or poor comprehension of English; neither of these is likely to change in the short term, but both limit access to prevention material.

Figure 3. STRUCTURAL FRAMEWORK

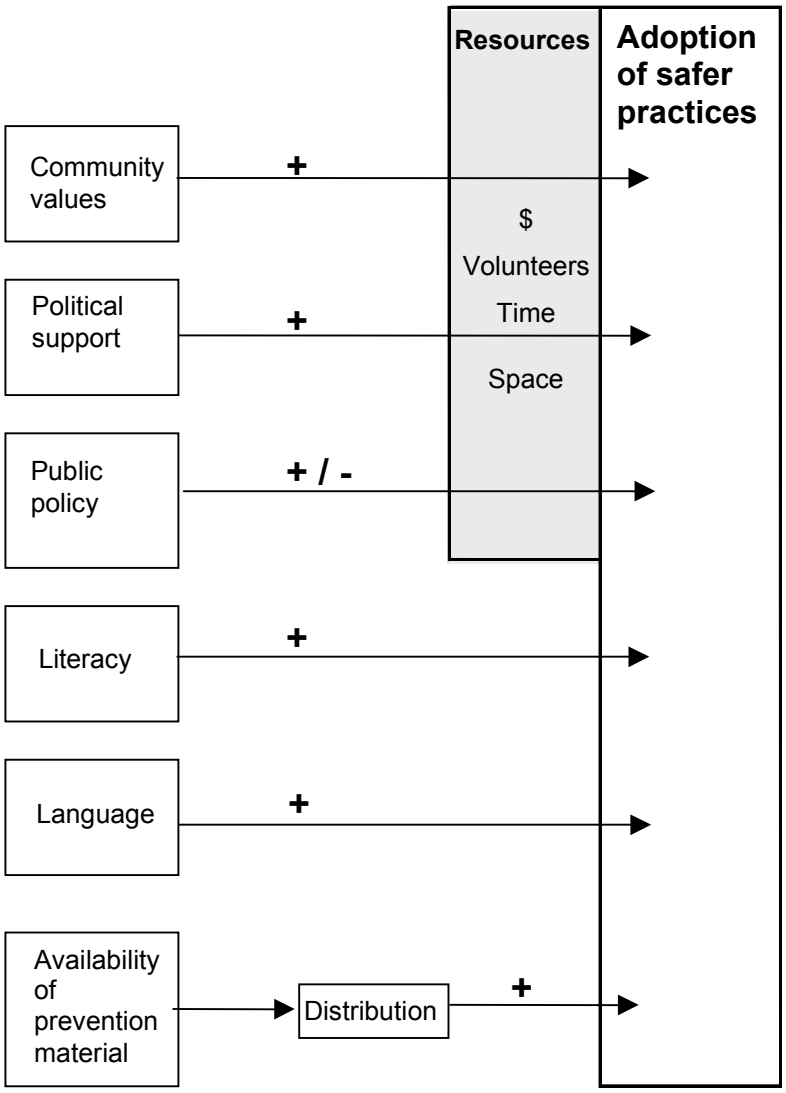


Table 3. STRUCTURAL CONSTRAINTS vs. PREVENTION MESSAGES

□	Control in sexual decision making by men	□	Women share in the decision-making.
□	Focus on the male condom	□	Search for female alternatives, such as female condoms, viricides
□	Low literacy	□	Often written for high-literacy audience
□	Low comprehension of English	□	Few Hispanic and other language prevention materials distributed
□	Legal access to care	□	Often assumes access to care

Based on these structural factors, several relationships are suggested:

3.1 Male-dominated sexual decision-making

- The greater the involvement of women in the sexual decision-making, the greater the likelihood of safer practices.

3.2 Language

- The greater the comprehension of safer-practices messages, the more likely they are to be adopted.

3.3 Laws and entitlements

- The greater the red tape and legal restrictions on testing and obtaining preventive health care, the less likely they are to be utilized.
- The greater the laws prohibiting the carrying or purchase of needles, the more likely it is that a person will share needles in using illicit drugs.

3.4 Political support

- The greater the political support for risk reduction and community cohesion, the more likely safer sexual behaviors will be practiced.

3.5 Community Cohesion

- The greater the infrastructure of the community and identity with a community that advocates safer practices, the more likely individuals are to engage in safer practices.

3.6 Availability of information

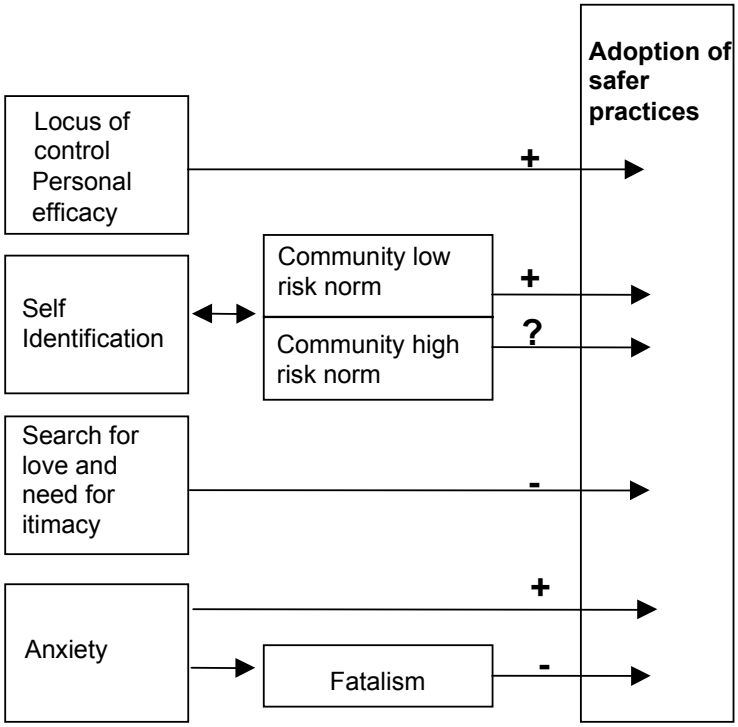
- The greater the access to clear information about safer practices, the more likely they are to be adopted.
- The more channels of communication broadcasting safer-practice messages, the more likely safer sex messages are to be received and reinforced.

- **PERSONALITY FRAMEWORK (Figure 4)**

- Personality factors include reasons for adopting safer practices that are part of the psychological profile of the immigrant or migrant populations. Personality factors include:

- Locus of control or self-efficacy, or the perception by the immigrant or migrant that they can control their environment and whether they will become infected by HIV
- Self-identification with their community
- Need for love and intimacy
- Anxiety and fear about HIV infection.

Figure 4. PERSONALITY FRAMEWORK



Several relationships are suggested between these factors and the adoption of safer practices:

4.1 Locus of control

- The more the person is able and empowered to adopt safer practices, and the more (s)he desires safer practices, the greater the likelihood that they will be adopted.

4.2 Self -Identification

- The more persons see themselves as part of a community that has a norm of safer practices, the more likely they are to adopt safer practices.

4.3 Need for love, intimacy, getting high

- The greater the need for intimate sexual contact, the more likely the individual will leave the decision about safer practices to his or her partners or peers.

4.4 Anxiety and fear

- A high level of fear without the tools to relieve it is related to high anxiety, which often leads to denial or fatalism.

These four frameworks were used to guide the development of the focus-group outline and questionnaire that are discussed below. They constitute the basis for the current research and the report of the findings.

II. METHODOLOGY

A. Design

The Latino Commission, the Finger Lakes Migrant Health Care Project (FLMHCP) and a number of New York City-based community organizations collaborated on the Special Populations Research and Training Initiative. The Latino Commission and the Partnership for Community Health (PCH) formulated the design.

The target populations were determined on the basis of statewide and N.Y.C. information which identified them as being significantly at risk for HIV infection and AIDS. However, not all the immigrant and migrant groups included in this project represent communities that have high rates of infection. As noted by the N.Y.C. HIV Prevention Planning Group (PPG), "the focus of PPG activities is on prevention" and, therefore, the sampling design ought to "be proactive by keeping down and/or lowering all seroprevalence rates, rather than to be reactive and exclusively focusing on groups with high seroprevalence rates."[6]

The selection of the population groups for this study was difficult for several reasons. First, the total cost of completing the project necessitated limiting the number of focus groups that could be completed. As a result, several other factors were used to select the comparatively few groups that were ultimately chosen for inclusion: incidence of HIV/AIDS in the home country; incidence and number of immigrants and migrants from each country in the United States; and the presence of a not-for-profit service provider who represented each particular immigrant or migrant group. Additional funds and more time would have enabled the inclusion of more populations; additional immigrant communities should be considered in a future study.

[6] N.Y.C. PPG, 1995.

The initial design included two main strategies of primary data collection:

- A series of focus groups with the selected sample of individuals from the target populations
- In-depth tracking with the selected sample of individuals.

The protocol and questionnaire for the focus groups were developed by PCH in conjunction with The Latino Commission. The questions were designed to gain information related to the four frameworks discussed previously. The Latino Commission was responsible for translating the documents into the language of the focus groups, as well as of implementing the focus groups. As noted previously, the protocol and questionnaire are shown in Appendices B and C, respectively.

The focus-group discussions, each having 8 to 10 participants, were designed to be led by a trained moderator and peer facilitators who were recruited through cooperating agencies. The moderators, who had fluency in the language of the migrant and immigrant groups, were trained in focus-group skills and were also responsible for writing drafts of the focus-group reports. The peer facilitators worked with the moderators to insure that cultural issues were included in their interpretation of each focus group. Peers also worked with a selected sample to insure that an in-depth tracking "diary" was completed.

The focus-group approach offered The Latino Commission and PCH an opportunity to gather important qualitative information. However, qualitative research does have limitations. The number of persons participating in each focus group may not, in fact, be representative of the views held by a majority of their particular communities. Some focus groups may have too few or too many participants, depending on the ease or difficulty of recruiting participants. In some instances, the focus groups had to be delayed until an appropriate moderator from a particular population could be identified.

The Latino Commission recruited the focus-group moderators from the identified communities, scheduled training sessions and monitored the execution of the study protocol. The Partnership for Community Health conducted several training sessions with focus-group moderators. However, due to problems in scheduling and recruiting, many of the trained focus-group leaders were not able to conduct the groups, and, in several instances, the role of peer facilitator was combined with that of moderator.

In order to implement the tracking of the immigrants and migrants who participated in the study, PCH, in close collaboration with The Latino Commission, developed and tested a low-literacy tracking diary, which was to provide contextual information about the environment and daily events that dictate an individual's use of time and to define practical barriers that limit access to prevention. Thus, in the diary were to be recorded daily use of time; encounters with the legal system and health care providers, and the results of those visits; the use of media, meetings, and interactions with friends and partners to determine the patterns of formal and informal communication; and other factors. Behavior was to be tracked in order to determine the types and degrees of risk, as well as to assist providers in providing risk-relevant advice in a culturally appropriate manner. The analysis of the diaries would serve to confirm the findings of the focus groups and to suggest channels and messages which might reach the populations at risk.

The completion of the diary required a greater commitment of time on the parts of both participants and peers than was planned. Therefore, this component of the study design was not fully implemented.

B. Recruitment of Focus-Group Participants

Seventeen focus groups were held among the populations indicated in Table 4. Heterosexual men and women and men who have sex with men (both gay self-identified and other MSMs) were recruited primarily by cooperating providers based on their ethnicity, gender, sexual behavior and, whenever possible to do so without compromising the confidentiality of the person living with HIV/AIDS, HIV status. In addition, separate focus groups were conducted with South American, Haitian and Dominican MSMs. In some instances, one-on-one interviews were held to supplement the findings of the focus groups.

Table 4. FOCUS-GROUP PROFILES

COUNTRY	SUBPOP.	# ATTENDED	LOCATION	HOST
Dominican Rep.	Male Urban	11	Wash. Heights	Alianza Domin.
Dominican Rep.	Female Urban	13	Wash. Heights	Alianza Domin.
Haitian	Female Urban	8	Brooklyn	HWHR
Haitian	Male Urban	8	Brooklyn	HWHR
Haitian	Male/Gay/Urban	5	Manhattan	Nathan Kerr
Haitian	Female Migrant	5	Rushville	Finger Lakes
Haitian	Male Migrant	6	Rushville	Finger Lakes
Chinese	Male Urban	10	Manhattan	APICHA
Chinese	Female Urban	7	Manhattan	APICHA
African-American	Female Migrant	5	Rushville	Finger Lakes
African-American	Male Migrant	6	Rushville	Finger Lakes
Jamaican	Female Urban	3	Brooklyn	CAMBA
Jamaican	Male Urban	4	Brooklyn	CAMBA
Jamaican	Male/Gay/Urban	5	Manhattan	Nathan Kerr
South American	Male/Gay/Urban	9	Manhattan	COLEGA
South American	Female Urban	8	Manhattan	LCOA
West Indian	Male Migrant	5	Rushville	Finger Lakes

As the program was designed, the focus groups were moderated in the languages of the participants. This worked particularly well, as it meant that persons familiar with the languages of the migrants and immigrants not only facilitated the discussions but were also sensitive to the concerns and obstacles the participants faced. As a result, facilitators could help the participants adopt safer practices that might prevent HIV infection and the progression to AIDS.

All the focus groups were audio-taped, and the moderators produced initial draft reports. As noted, during each group, participants completed the questionnaire, which was analyzed to determine basic demographics, awareness, belief and attitudes about HIV/AIDS and sources of information. The questionnaire was completed by 113 focus-group participants.[7]

[7]Several of the questions on barriers were omitted from the questionnaire for the Latino groups, and there was little quality control on the collection of the questionnaire data. Accordingly, there is considerable data missing throughout.

C. Analysis

The moderators, along with The Latino Commission, prepared the draft reports. Data from the questionnaires was entered by PCH and analyzed using the Statistical Package for the Social Sciences (SPSS) to produce bivariate tables. This report was written by PCH and the Latino Commission on the basis of the individual reports and the data from the questionnaires.

Due to small sample sizes and non-random selection procedures, the focus groups and questionnaire data are not representative of their immigrant and migrant populations. Rather, they provide valuable *qualitative* information, such as basic demographics for each participant group and their awareness, attitudes and beliefs about HIV prevention.

III. FINDINGS

The following sections provide the demographic profiles and highlights from each of the immigrant and migrant populations. According to the frameworks of prevention, this section also describes the safer and unsafe practices of the focus-group participants. The initial focus-group reports, completed by the moderator of each group under the supervision of the Latino Commission, are included as Attachment 5.

The following sections are organized according to the four theoretical frameworks and integrate the relevant findings from each of the focus groups.

DEMOGRAPHICS

A. Chinese Participants

Eighteen Chinese individuals participated in two focus groups. One group consisted of 10 men and the other eight women. The average age was 41, with ages ranging from 28 to 57 years. One participant was a U.S. citizen.

Two participants were employed part-time, eight full-time and five reported some other form of employment. Six participants reported an income of more than $20,000, while three reported incomes of less than $5,000.

The Chinese participants were relatively highly educated, with over 75% reporting some form of college education. Their occupations included a doctor, a computer consultant, a business manager and a mechanical engineer.

They also represented a variety of religions, including Islamic, six non-traditionalists, one Buddhist and one Christian. Four reported having no religion.

The majority of the Chinese participants lived in rented apartments. One lived in his own home, one in a rented room and another in a group home. Eight participants lived alone, while the others lived with partners, children, family or friends. Eleven had children, with most having one child. The ages of the children ranged from two to 31 years. None of the respondents reported having a child who tested HIV+. Two participants indicated they were interested in having children in the next few years.

Only five participants responded to the question regarding the number of sexual partners they have had in the past year. Of these, none reported having had more than two partners. One male and one female reported being bisexual, and one female indicated having had same-sex contact during the past year.

Eight participants indicated they were in monogamous relationships with a primary sexual partner, and three reported that they used condoms frequently. An additional three said they sometimes used condoms. The average condom-use among the Chinese participants ranged from "sometimes" to "frequently". On average, they reported they rarely used either birth control pills or some other forms of birth control.

One participant reported having had a sexually transmitted disease. Three had been tested for HIV, and one did not know whether he had been tested or not. None had received pre- or post-test counseling. One participant knew that his partner had been tested for HIV, while seven others did not know if their partners had been tested. None of the participants reported a positive test result for their partners.

Among the Chinese participants, the average condom use reported was the same as for other participants -- between "rarely" and "sometimes." While four Chinese participants reported never using condoms, another four reported using condoms frequently. A few of the Chinese women suggested that poor utilization is less because of problems using the condom but, rather, that use is determined by what condoms represent. One Chinese woman said, "Well, of course, we are women, you know, we always show more shy and conservative if you are going to do 'that thing'." Another woman added, "Well, women should be shy and conservative; otherwise men will think that you are bad woman."

B. Haitian Participants

A number of group sessions were held with Haitian participants, with a total of 21 individuals. Separate sessions were held with women, men, MSMs and migrant workers. (Results of groups with migrant workers are discussed in a subsequent section.) Fourteen men and seven women participated in the focus groups.

On the average, the Haitian participants were younger than other migrant and immigrant populations. Their ages ranged from 19 to 34, with an average age of 25. Six reported having U.S. citizenship -- more than other participating groups.

The Haitian participants reported a variety of educational training, with more than 75% having a minimum of a high school education. Nearly 50% had some college education. Among the six Haitians reporting any form of income, three reported having incomes of less than $5,000, while three reported having incomes of more than $30,000.

Half of the Haitian immigrants were employed, either part- or full-time. Among the occupations reported were caseworker, teacher, factory worker, home attendant and plumber.

The majority of the Haitian immigrants reported being either Protestant or Catholic. Five reported having no form of religion.

Thirteen participants reported living with family, including parents or other family members, and one reported living with his partner. Six participants lived alone, and none reported living with children. Two participants reported having children; one had two children, and the other had six. None of the children had been tested for HIV. Over 50% of the participants reported that they plan to have children in the future.

The male Haitian participants reported having between zero and 14 male sexual partners in the past year, with an average of three, and between zero and 18 female partners, with an average of four. The female participants reported having a maximum of three male partners and zero female partners over the past year.

Sixty percent of the participants reported they had one person they considered to be their main sexual partner. However, only 30% -- four male participants -- reported being monogamous. None of the women reported having sex outside of the relationship, yet they were uncertain about their partners' sexual activities.

Nearly 85% of the men and more than 50 % of the women reported using condoms "frequently". Very few participants reported using any other form of birth control.

Two participants reported having had a sexually transmitted disease, and eight reported having had an HIV test. Six participants had received pre- and post-test counseling. Five participants knew that their partners had been tested, and two reported positive results. More than half of the participants did not know whether their partners had been tested.

The Haitian participants, who tended to be more aware of AIDS than other populations, reported the highest condom use, with participants using condoms from "sometimes" to "frequently" during the past year. Close to 75% of the participants indicated frequent condom use during the past year. Only two reported they had never used a condom. Yet, some of the Haitian women, like the Chinese women, reported that suggesting condom use would send the wrong message to their husband or boyfriend. As noted by the moderator of the Haitian group, "Culturally, there is a tendency for Haitian women to be sexually at their husband's disposal." Some participants reported that suggesting condom use can be interpreted as questioning the male's authority, an indication of infidelity, an admission of another relationship or a confession of being a homosexual or prostitute.

C. Jamaican and West Indian Participants

A total of 11 Jamaican and West Indian individuals participated in three focus groups, including eight men and three women. The average age of the participants was 39, with range of from 25 to 68 years. Two participants were U.S. citizens.

Six Jamaicans reported having received high school educations, and most said they were employed, with six out of 11 reporting they were employed full-time. They held positions as teachers, childcare workers, computer consultants, outreach workers, therapists and tailors. Three were looking for employment. Five reported an income of less than $10,000, while three reported incomes of more than $30,000. Seven of the participants reported being Protestant.

More than half lived in rented apartments with spouses, family or friends. Three reported owning their own homes. Six reported having children, with one having as many as five children. The children's ages ranged from three to 50 years. None of the children had tested positive for HIV. The majority (n=7) reported they did not plan to have more children, yet very few reported using any form of birth control. Only four participants reported they used condoms "frequently."

None of the women reported having a primary sexual partner. Two out of the three women reported having had no sexual partners during the past year. The third woman reported having one male partner in the last year.

The males reported having had numerous sexual partners during the past year, both male and female and as many as five male and two female partners. Six of the men reported having one primary partner, and one reported being monogamous.

One male participant reported having had a sexually transmitted disease. Four men had HIV tests, and two received pre- and post-test counseling. Three men knew that their partners had HIV tests, and two knew that their partners had tested positive.

This group reported the lowest condom use, on average, of any of the populations studied, between "rarely" and "sometimes." Four participants reported they had never used a condom during the past year, and three reported they had used a condom "rarely."

D. Dominican Participants

A total of 24 Dominicans participated in the focus groups, including 11 men and 13 women. However, complete demographic information is available only for the female participants.

The average age of the women was 39, with a range of from 19 to 54 years. Five participants reported having U.S. citizenship.

None of the women reported being employed. Two were students; three were on full-time disability; four were homemakers; and three were looking for work. Eight reported having a household income of less than $10,000. The others did not provide income information.

Four of the women reported having lower than a grade-school education, while the others reported having completed high school, trade school or college.

Nine of the women were Catholic.

Information on housing arrangements was available for all 24 Dominican participants. The vast majority reported living in rented rooms or apartments, with more than half living in apartments or rooms paid for by the Government. One participant reported living in a shelter. None lived in a private home.

Most of these participants lived with their children or other family members. Only one reported living with a partner or spouse. Twenty-two of the participants had children, with most having one or two. Two individuals reported they had six children. The children ranged in age from under one to 29 years. None of the participants reported having an HIV+ child. Fewer than 20% reported an intention to have children in the future.

On the average, the women reported having one male sexual partner over the past year, with some reporting no partners and one reporting three partners during the last year. None of the women reported having had same-sex partners.[8] The men reported having had an average of two male partners and three female partners during the past year, with the maximum number of sexual partners, male or female, being five. There was some degree of confusion among the male participants about what constituted a primary or main sexual partner and, therefore, they did not respond to this question. By comparison, fifty-eight (58%) percent of the women reported having a primary sexual partner.

Sixty percent of the women said their sexual partners never used a condom, while over 45% of the men (n=5) reported using condoms "frequently." The majority of the participants did not use any other form of birth control.

More than 25% of the participants reported having had a sexually transmitted disease. Over 70% reported having had an HIV test, with 14 participants -- seven men and seven women - having received some form of counseling. Fourteen participants -- 8 men and 6 women -- knew that their partners had an HIV test; 3 men reported knowing that their partners had tested positive.

The Dominican participants reported an average condom use of "rarely" to "sometimes," with eight reporting they had never used a condom during the past year. Over 50% of the women reported never having used a condom during sex. Among the men, both straight and gay, it was agreed that "should the opportunity arise," they would practice unprotected sex. The women, again, associated asking their partners to wear a condom with rejection or distrust, with one woman reporting fear of offending or antagonizing her partner by asking him to wear a condom, "especially if he's been out in the street." Additionally, two of the women were trying to get pregnant, and that precluded practicing protected sex.

[8] The Spanish-language questionnaire completed by the Dominican women did not ask about same-sex partners or sexual activity outside of the primary relationship.

E. South American Participants[9]

Eleven South American MSMs participated in the focus group convened by the Latino Commission. Most identified as Latinos with no specific ethnic identity. For those who reported a country of origin, two were Mexican, one was Colombian and one was Dominican.

The average age for the men was 38, with a range of from 22 to 46 years. One participant was a U.S. citizen. During the focus-group discussion, most of the participants reported they had lived in this country for more than five years.

Six of the men were unemployed and receiving full disability; one was employed full-time as a house-man; two were students; one was looking for work; and the other volunteered as a community educator. All of the participants reported an income of less than $10,000, with eight reporting an income of less than $5,000. The majority of the men had more than a high school education, yet two men reported having completed grade school or lower.

Eight of the men were Roman Catholics; one was Buddhist; and one reported no religion. One participant did not respond to this item.

Most of the men reported living in rented rooms or apartments, with more than half living in apartments or rooms paid for by the Government. One participant reported being homeless. Ten of the men reported living alone and one living with his partner. None of the participants reported having children; four participants reported they did not plan on having any children in the future.

The men did not respond to the questions pertaining to sexual partners, and from the moderator's account it appears that they were unclear about their own definition of primary or main partners. Nor were they sure how to classify their past sexual experiences.

Nonetheless, nine of the m reported using condoms "frequently" when having sex, while one reported never using a condom.

F. Migrant Participants

Twenty-two individuals participated in the focus groups for migrant workers, which were convened by the Latino Commission, the Finger Lakes Migrant Health Care Project (FLMHCP) and the Hudson Valley Migrant Health Program (HVMH). Eleven of the migrant workers were Haitian, six were African American and five were of Jamaican or West Indian descent.

Eighteen of the migrant workers were male and four were female. A focus group was also held with five African American women who were initially recruited to participate in the migrant workers' group. However, during the focus group discussion it became known that they were no longer migrant workers, and their reports are not included in this analysis.

The average age of the migrant workers was 41, with a range of from 28 to 52. Six reported they were U.S. citizens.

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[9] The Spanish-language questionnaire used by the South American MSMs was incomplete and did not include items beyond question number 20.

Most of the participants reported having had a minimum of a high school education. Four reported grade school as the highest level they had achieved, and five reported having had some college education. The majority of the participants reported they were employed part- or full-time, or seasonally. Yet, 50% reported having an income of less than $10,000.

Sixty-four percent reported they were Protestant; five were Catholic; two were non-traditionalist; and one reported having no form of religion.

Most of the migrants reported living in rental apartments or rooms; seven reported living in group housing with other workers. Eight reported they do not live with family and the remainder that they lived with spouses, children or other family members.

Nineteen of the migrants reported they have children; 10 said that they plan to have more in the future. Most had between two and four children; two had eight children. The children's ages ranged from under one to 37 years. None of the children had tested HIV+.

None of the men reported having had a male sexual partner in the past year; on the average, they reported having had three female sexual partners during that time. One participant reported having had as many as 15 female partners. The women reported having had an average of one male sexual partner, with one woman reporting four partners. None of the women reported having had any same-sex contact.

Seventy-five percent of the men and 50% of the women reported having a primary sexual partner. Seven of the men admitted having had sex outside of their relationships. None of the women reported having had sex outside of their relationships. Five men reported they used condoms "frequently," and four men and three women reported they used condoms "sometimes." Very few participants reported using any other type of birth control.

Eight participants reported having had a sexually transmitted disease. Fourteen said they had HIV tests, with nine having received some type of pre- or post-test counseling. Nine knew that their partners had HIV tests, and two knew that their partners' results had been positive.

SAFER AND UNSAFE PRACTICES

A. Injection Drug Use

The findings provide very little information about prevention strategies for limiting unsafe needle use. Of the more than 100 focus-group participants, only five reported having ever shared needles. None of the Haitians or migrant workers reported sharing needles in the past year. One Jamaican, one Chinese participant and one Dominican reported they had shared needles on rare occasions. One Chinese respondent reported having sometimes shared needles, and one Dominican reported sharing needles frequently in the past year.

B. Condom Use[10]

The focus-group participants indicated varying levels of condom use. As discussed below, the findings provide some information about the reasons a person might have for deciding on whether to choose to have protected or unprotected sex. Participants were asked to report on their safer sex practices over the last year. On the average (N=92), they reported having used condoms from "rarely" to "sometimes," with close to 30% reporting they never used a condom during the past year. Thirty-six participants reported they used condoms frequently.

Immigrant and migrant participants reported that condom use was not considered a necessity, especially when they were having sex with their regular partners or spouses. All participants said they almost never practice protected sex with their spouses or main partners, and that "it depends on who you are having sex with, and then you decide to use condom or not."

For some women participants, the suggestion that a condom should be used presented a risk of violence from their partners. That is, if the partner interpreted the suggestion as questioning his integrity or the woman's fidelity, the result could be a violent confrontation.

The focus-group discussions revealed that many immigrants decide to engage in unprotected sex. For example, the decision by a Chinese woman to have unprotected sex was based on her understanding and trust of her partner. A Chinese man said that one element of his decision was the "type of woman" with whom he had sex.

For many immigrants, including the Dominicans and Chinese, condom use was more related to birth control than AIDS prevention. For most of the Haitian women and men, having children was a blessing and since condoms inhibited birth, they were undesirable.

C. Sexual Intercourse While Under the Influence of Alcohol or Drugs

A risk factor for HIV transmission is engaging in sex while "high." When asked directly about drug use while engaging in sex, 66% of the participants (excluding the migrant workers) reported they were never high while having sex. One migrant worker reported frequently being high while having sex, and eight others reported sometimes being high while having sex.

[10] This item was missing from the questionnaire administered to the South American MSMs.

Nonetheless, during the focus-group discussions, the use of alcohol and other drugs was often associated with "having a good time." For example, when asked what they do for fun, the Jamaican men said they "dance, smoke, drugs, play dominoes and [go] girl hunting." Younger participants were also more likely to engage in drug use and socialize in clubs and on the street. Cognizant of the potential risks, one Dominican woman reported that she feared going out with a friend, having a few drinks and losing control because, under those conditions, she might fail to protect herself.

FACTORS RELATED TO SAFER AND UNSAFE PRACTICES[11]

A. General Trends

Three general patterns emerge from the responses of the focus groups:

1. Regardless of participants' ethnic or cultural backgrounds, a substantial difference is observed in the awareness and knowledge about HIV between MSMs and heterosexuals. MSMs, generally, are more informed, more likely to have engaged in testing and prevention activities and are more open to discussing sexual transmission of HIV.

2. There was fear among migrant and immigrant participants that they would be stigmatized by a diagnosis of HIV infection. Many immigrants and migrants fear that a diagnosis of HIV or AIDS will mean that they are thought to be sexually promiscuous, drug users or homosexuals. MSMs fear they will be labeled as gay by their employers, family and community, with the likely consequence that they will lose their jobs and be made to suffer isolation and shame. Undocumented immigrants fear they will be deported and ostracized by their communities.

3. There was an information gap between the generations of the migrant and immigrant populations. Younger participants tended to have better English language skills and find social networks outside their ethnic cohorts, such as with others in the workplace, school or neighborhood. They also tended to be more knowledgeable about HIV and AIDS, but were more likely to engage in less-safe practices. Older immigrants and migrants tended to form stronger bonds with those who spoke their language and understood their cultural heritage. Regardless of age, those who did not have a good command of English tended to socialize within their own communities and to rely on these for most services.

[11] Given the reported low drug use by the focus-group participants, the discussion in the following sections focuses on the factors related to safer or unsafe sexual practices.

B. INFORMATION PROCESSING FRAMEWORK

(1) Awareness of AIDS as a Problem. The Dominican MSMs, South American MSMs and the Haitian groups recognized AIDS as a major problem in their communities. As a consequence, these persons are more likely to consider AIDS as a greater factor in their decision-making about sexual practices than the other ethnic or immigrant and migrant groups. One example of the effect of this awareness is the greater condom use reported by Haitians compared to the condom use reported by other immigrant populations. By contrast, the heterosexual Dominican men, Chinese men and women and Jamaicans did not perceive AIDS as a major problem in their communities.

(2) Awareness of Serostatus. According to the questionnaire responses, the majority of Dominicans and migrant workers reported that they had been tested for HIV, and, among all groups, a total of 48 individuals reported having had an HIV test. The reasons for not being tested vary. African American women, for example, reported they were aware of HIV/AIDS and most knew someone among their family or friends who are infected. However, when asked in the focus group why some would not get tested, several responded that they feared the results. They reported that they could not cope with being HIV+ and, therefore, did not want to know their status. Jamaican men who reported they knew about testing said they may be too embarrassed to get tested in their own areas because, if they tested positive, people would find out. The Chinese women, by contrast, appeared not to have sufficient awareness of testing to seek it out, and they perceived that their risk was low.

A bare majority of those who had been tested reported they had received pre- and/or post-test counseling. Migrants or immigrants did not mention counseling as providing motivation for the adoption of safer practices.

(3) Awareness of Others Who Are Infected. Not surprisingly, the immigrants and migrants in communities more affected by AIDS were much more likely to know someone infected with HIV. In the focus group with African American women, one participant spoke about losing her son to AIDS; another reported she had an infected daughter; and everyone knew of several persons who had died of the disease. By comparison, the Jamaicans did not have as much personal experience with AIDS.

Among the immigrants, the Dominican MSMs, whether they were openly gay or not, had contact with persons who had HIV and AIDS. One reported he was HIV+, and the others reported having had varying levels of contact with persons living with the virus.

Haitians, whether immigrants or migrants, were more likely than other heterosexual migrants and immigrants to be aware of someone who is infected.

In general, participants who knew someone infected by HIV or having AIDS did not appear to engage in fewer unsafe practices than others. Instead, they were more likely to rationalize how they were different from those who were infected (*i.e.*, not homosexual, not a drug user, not promiscuous). For example, some Haitian women were clear that once a person was diagnosed with AIDS they tried not to associate with them because, they reported, there is huge stigma associated with having AIDS. It was like *"maladi lamo"* (a kiss of death).

(4) Awareness and Beliefs Related to Safer and Unsafe Practices. Awareness and knowledge about basic facts of HIV infection, routes of transmission and the progression to AIDS varied among the participants. In general, the Dominican MSMs, South American MSMs and Haitians were the most knowledgeable, and the Chinese heterosexuals and Jamaicans -- particularly the women -- were the least knowledgeable.

Questionnaire participants reported having a relatively good knowledge about the ways HIV is transmitted. Almost all participants said sexual intercourse without a condom with a casual sexual partner was a high-risk activity. Notably, four out of the 21 Dominicans, two migrants and one Chinese participant thought unprotected sex with a causal partner was a low-risk activity. All but six participants said sharing needles for drugs such as cocaine and heroin was a high-risk activity.

At the same time, there was less certainty about behaviors that are low risk. All immigrants and migrants considered oral sex to be as great a risk as sharing needles and sexual intercourse without a condom. Kissing tended to be viewed as moderately high risk among the Jamaicans, Chinese and Dominicans, while the migrant workers felt that deep kissing someone who is HIV+ represents a high risk. Transmission from toilet seats was felt to be of medium-to-high risk by nearly half the Dominicans and migrant workers.

In the focus group discussions, participants elaborated on the subject of risk. The Dominican women, who were mostly heterosexual and homemakers, reported being monogamous. Yet, they were more likely to say they felt at risk from unprotected sex with their main partner than other immigrant women, except for Jamaicans. Several women reported that they knew their main partners had sex outside their relationship. One Dominican woman denounced men's "irresponsible" behavior of going around with different women, not protecting themselves and not protecting their partners.

In the questionnaire, more than one-third of the Chinese, Jamaicans, Dominicans and migrants reported that only people with many sexual partners become HIV-infected. The Chinese participants were also much more likely to think that only homosexuals become HIV-infected. This was confirmed in the discussions.

Another common misperception among participants was that one could tell if people were infected with HIV by the way they look. In the questionnaire, the migrants were particularly likely to hold this belief.

Most of the participants knew that it may take several years for a person who is infected with HIV to become sick with AIDS. Yet, four Chinese, four Haitian, two Jamaican, two migrants and one Dominican disagreed with the statement.

Other misperceptions that were articulated in the focus-group discussions included the following:

- the belief among some Chinese, Haitians and Jamaicans that some members of their communities were immune to HIV;

- the belief among some Haitians that AIDS was caused by some form of hex or voodoo-related spell;

- the belief among some Jamaicans and Haitians that an AIDS diagnosis was equal to a death sentence, that is, there was little awareness among these populations that AIDS can now be treated and that it is not necessarily a "death sentence"; and

- that people diagnosed with AIDS lose their jobs. This belief, however, may be grounded in fact, although among the Chinese and African Americans it was not reported to be a big problem. However, for the South American MSMs and Haitian participants, it was reported to be a medium or big problem that kept them from learning more about HIV/AIDS.

(5) Attitudes About Safer and Unsafe Sex. The discussions did not reveal deep-seated negative attitudes about condom use or other forms of safer sex *per se.* Rather, the negative attitudes related to safer sex arose from the association of condoms with homosexuality, promiscuity and drug use. For example, the heterosexual Chinese, Dominicans and Jamaicans each expressed that they tended not to engage in safer practices because they felt they would be labeling themselves as gay, drug users, or sexually promiscuous. For Dominican and South American MSMs, there was a fear that the use of condoms would reveal their sexual identity and lead to stigmatization and isolation.

In the focus groups, several men from different populations expressed positive attitudes about unsafe practices, particularly unprotected sex. Several male participants said the spontaneity and the feel of unprotected sex was preferred to sex with a condom.

C. Normative Framework

(1) Social Groups. All groups reported that friends are the third most important source of information. Participants spoke of the importance of "having a good time" with friends and doing activities together.

Participants said that their friends were, generally, people in their immediate environments, such as co-workers, neighbors or schoolmates. However, there was also a special affinity for people from their home countries. Most of the participants lived near others of their nationality and had a community with cultural bonds. The Chinese were more dispersed, but they repeatedly noted that they frequently returned to Chinatown in Manhattan for the sense of community and culture.

Some communities reported that they were more self-contained than others, which meant that they had little interaction with people from other groups. The longer the length of their stay in the United States, or the younger the immigrant or migrant, the more likely they were to associate with persons of different national and ethnic groups.

The Dominican women spoke of spending time with people of different ethnic groups. Second only to the African Americans in the number of U.S. citizens who participated in the project, the Dominican women reported that they had established themselves in their communities and that most of them plan to reside in the U.S. permanently.

For the Jamaicans, the church reportedly provides a center for much social activity, including playing dominoes and bingo. For Haitians, social groups also include the church, as well as sports teams.

(2) Peer and Partner Interaction. Peer and partner pressure appear to play a large role in the decision to engage in safer practices. Regardless of ethnicity or migrant and immigrant status, participants often reiterated that the opinions and reactions of their peers were primary considerations. For Jamaicans and Dominicans, there was an "image" to uphold. For the Chinese, it was the perceived reaction of their partners that inhibited safer sexual practices.

For many immigrants, getting together with friends was the primary social activity. This was particularly true for newer immigrants and migrants who spoke little English and preferred to socialize with persons who spoke the same language and had the same social or cultural background.

In the questionnaire, the Chinese, Dominicans, migrants and South American MSMs indicated that friends were a very important source of information about HIV/AIDS. Family was less important among most groups, with the exception of migrants, for whom family and friends were equally important. For some groups, such as the Chinese and Jamaicans, the family was reported to be a poor source of information about HIV/AIDS. In the focus groups, the Chinese, Dominicans and Haitians mentioned that information from health care professionals was taken more seriously than that from either family members or peers.

(3) Media. Participants reported that television, newspapers and magazines tend to be a major source of information. Among the many who identified television as their primary source of information, cable foreign language (Spanish or Chinese) television was frequently mentioned as a source of information. Dominican women reported that they relied on talk shows, soap operas and news programs for the latest information and popular opinion. In their opinion, television programming could play a greater role in educating the community than it does.

South American MSMs were more likely to consider newsletters, magazines and other written material as their main source of information than other migrant or immigrant groups. This is consistent with their higher reported literacy rates. In the focus group discussions, both the Chinese male and female groups mentioned the Chinese World Journal as a source of information. Similarly, participants of the Jamaican group, who were among the most highly educated immigrant groups interviewed, also often mentioned receiving information from the newspaper.

Many participants said that they did not read brochures and pamphlets, and that these, as well as handouts, often did not reach their targeted populations. Language was reported to be the greatest barrier, but among those with less awareness of AIDS, there may not be the interest in learning about the disease. Some immigrants also said that they felt they would be labeling themselves as homosexuals or drug users by seeking out information about HIV/AIDS.

Some immigrant populations wanted more information to be accessible. For example, one of the Dominican women felt that it was the government's fault that so many people were getting infected because they failed to provide enough information for the community. Another participant echoed the same sentiment and felt that education materials should be designed to reach everyone. In her opinion, they should be distributed along with the fliers that announce local politicians who are running for office.

(4) Providers. In the questionnaire, doctors and hospitals were identified as among the most important sources of information for Jamaicans, migrants and South American MSMs. They were less important for the Chinese and Haitians. As noted above, the Chinese reported that they relied more on written material; the Dominicans relied more on community-based organizations (CBOs) and support groups. Haitians, Dominicans, South Americans and migrants all cited CBOs as a main source of information about HIV/AIDS.

D. Structural Framework

For immigrants and migrants, some of the greatest barriers to prevention are the structural factors that limit access to information. For migrants, HIV prevention and clinic care are restricted by time and transportation. Outreach is not highly funded, and these focus group participants reported that they would be unlikely to seek information because they felt that their employers would misinterpret their acts as indicating that they were infected.

Moreover, community support for HIV prevention is relatively weak in most of the migrant and immigrant communities. Several Haitians and Dominicans, for example, said that their peers generally avoid persons known to be HIV+ and those having AIDS.

Public policy with regard to entitlements for immigrants is also an issue. South American participants considerably more often said that their fear of losing their immigrant status was a big problem in their seeking HIV prevention information, while migrants and Dominicans said it was a medium-to-small problem. In the focus groups, many of the immigrant participants noted that they feared deportation and trouble with the law, and they did not trust that their HIV status would be kept confidential.

The Dominicans and Haitians most often mentioned that they perceive the current political environment as "hostile" to immigrants. A few of the Chinese women noted that one of their motivations to have intercourse was to enable them to obtain a green card. For many Dominicans and Jamaicans, the lack of access to care meant that they would go back to their own country to seek medical care.

The Chinese did not rank any of the structural factors as big problems in obtaining HIV prevention information. Rather, the factor they rated highest (between a small and medium problem) was the difficulty of finding prevention information in their language.

South Americans, migrants and Haitians reported that the biggest problems they face are the lack of available information and someone to talk to in their language. In contrast, the Dominicans, Jamaicans and African Americans found language to be a relatively small barrier.

The experience of conducting the focus groups and getting the feedback from the moderators suggests a conclusion that literacy is a significant barrier for HIV prevention among the participants. Many persons had poor understanding of the difference between HIV and AIDS, and the terms, "protected" and "unprotected," sex and sexual identification, were not clearly understood.

E. Personality Framework

(1) Locus of Control. In general, participants reported a high level of control over their own actions. The immigrant and migrant men tended to have a higher locus of control than the women.

Among the five groups responding to the items of this framework, overall, the Chinese male participants indicated the lowest sense of self-efficacy, while the Jamaican men reported the highest.

Regarding decision-making during sex, the Jamaican and Dominican female participants, more than any others, reported feeling that their partners usually control what they do in bed.

(2) Self-Identification with Community. In the focus-group discussions, most of the migrants and immigrants identified with their ethnic communities, while among other immigrant and migrant communities the norm was unsafe practices, which reinforces these practices. Similarly, some Haitian and Dominican participants noted that denial in their communities contributed to their own denial of the impact of AIDS. Among the Dominican, Haitian and South American MSMs, there was a much greater identification with safer sex norms.

(3) Anxiety and Fear. The participants' fears ranged from being deported because of their HIV status to accidentally pricking themselves on the finger with an infected needle. One of the participants in the Dominican women's focus group reported feeling that AIDS was everywhere: "It's destroying everything. No matter how old, what size or anything."

In general, high anxiety does not appear to lead to adopting safer practices. In fact, increasing anxiety without offering ways to reduce risk appears to reinforce a feeling of fatalism. Several of the participants in all groups indicated that they felt relatively fatalistic about AIDS.

IV. CONCLUSIONS AND RECOMMENDATIONS

The Special Populations Research and Training Initiative has applied four theoretical frameworks that identify key elements which contribute to the adoption of safer practices among immigrant and migrant populations. As expected, each population has unique characteristics.

Haitian participants tended to be the most aware of the epidemic, and they expressed a sense of community identification. However, they also indicated there are substantial barriers to obtaining and acting upon HIV prevention information. The greatest barriers are the denial of the epidemic's impact on their community and the stigmatization of those living with HIV and AIDS.

The Chinese heterosexual immigrant population was relatively unaware of the epidemic and had little direct experience with HIV/AIDS. The rate of infection among this population is very low, and the participants perceived their risk to be low as well.

The Jamaicans and West Indians appeared to be more integrated into the larger immigrant and migrant community, with West Indian MSMs tending to be considerably more informed than their heterosexual counterparts. In general, the comments among these participants suggested that this community has little unity over HIV/AIDS prevention efforts.

South Americans were a diverse group and participants did not indicate that there was a single Hispanic voice on HIV/AIDS issues. The South American MSMs, like the other immigrant MSM populations, had a much higher level of awareness of HIV prevention.

The Haitian and African American migrants reported that their greatest barriers to prevention were the fear of being identified as a person with HIV and the unemployment and stigmatization that would result. Their limited access to material and fear of being labeled as HIV+, homosexual or drug users are substantial barriers to obtaining information about and adopting safer practices.

The following conclusions and recommendations follow the four prevention frameworks.

A. Information Processing Framework: Prevention Suggestions

In general, messages that raise awareness of HIV should correspond with reality. For example, recent Chinese heterosexual immigrants correctly perceive that HIV is not presently a significant health problem for their community, and messages about the risk of HIV should reflect their experience. Overstating risk can lead to immigrants discrediting HIV prevention information.

Alternatively, Haitians, for example, do perceive HIV/AIDS as an issue in their community, and they have a relatively high rate of infection. Designing prevention programs that focus on factors affecting their safer practices without stigmatizing the community will be a challenge.

(1) Awareness of serostatus. The theory suggested that awareness of serostatus combined with counseling increases perception of risk and, consequently, contributes to adopting safer behaviors.

The focus group participants suggested that awareness of persons living with HIV and AIDS in the migrant and immigrant communities does not serve this purpose. None of the participants mentioned testing as a

strategy to determine their risk in their community. The Dominicans and Haitians reported substantial numbers being tested, but these groups also had a larger number of MSM participants who were, in general, much more likely to be tested as part of the gay community.

Counseling is the part of testing that is most related to adopting safer practices. The lack of adequate counseling for these communities is a major obstacle in using testing as a prevention tool. While migrant groups generally said they received post-test counseling, there is little evidence of effective pre- or post-test counseling among immigrant groups. The majority of tested participants did not recall post-test counseling, and most said they did not receive counseling.

Therefore, if testing is to be a major strategy for HIV prevention, immigrant and migrant communities must first be convinced of its benefit and assured that all testing will be confidential and will not result in discrimination. Information about the location and value of testing should be widely distributed among the populations at greatest risk. All persons should be counseled about high risk behaviors and should be offered risk reduction strategies.

(2) Awareness of Others with HIV: The theory suggests that awareness of others with HIV will increase perception of risk and adoption of safer practices.

Awareness of friends or others with HIV and AIDS does not appear to motivate migrants or immigrants to engage in safer practices. Rather, most participants appear to try and distance themselves from those with AIDS. Instead of heightening the feeling of risk, there is a tendency to think, "I am not a drug user, or homosexual, or promiscuous. Therefore it can't happen to me."

This suggests a need to demonstrate that AIDS is a risk for community members and to develop strategies in communities to remove the stigma from those with AIDS. Encouraging buddy systems and providing community involvement may improve acceptance.

(3) Awareness of Safer and Unsafe Practices and Beliefs about Modes of Transmission. Immigrant and migrant participants whose populations have the greatest number of HIV infections had a general awareness that sex and drug use are major modes of transmission. However, they also had low awareness about the methods of safer sex and many misperceptions about modes of transmission.

Among the most affected populations, the Haitian and South American MSM participants' higher level of knowledge and perception of higher risk appeared to be related to their reports of safer practices. However, they also had misperceptions, e.g., AIDS can be transmitted by kissing or from toilet seats, and these can lead to engaging in ineffective preventive behavior. Participant comments suggest there is a need to clarify ways that you cannot contract AIDS, particularly among the Chinese, Dominican and Jamaican immigrant populations. There is little evidence that immigrants are able to distinguish between activities that would place them at substantial risk and those of lower or no risk.

Other misperceptions that could be addressed in prevention campaigns are:

- Homosexuals and drug users are the only populations infected by HIV.
- HIV status can be determined by the appearance of an individual.
- Certain individuals are immune to infection.
- HIV infection and AIDS are caused by a hex or spell (belief held primarily among Haitians).

In general, a campaign could be initiated that has some basic messages:

- Anyone is vulnerable to HIV if they engage in specified high-risk behaviors.
- Infected persons represent different sexual orientations and different behaviors.
- More widespread acceptance of alternative family and lifestyles can result in safer practices.
- Major modes of transmission can be re-emphasized and misperceptions about transmission can be corrected.

Finally, there is little awareness that new treatments can mean HIV infection no longer necessarily leads to death in the short term, and immigrants and migrants should be shown that infected persons are less likely to have or show manifestations of opportunistic infections or HIV with the new medications. At the same time, from a primary prevention point of view, they should be shown the devastating consequences of HIV infection, even if it will not necessarily lead to death in the short-term, and there should be substantial education among the communities about the advantages of early treatment.

(4) Attitudes. The greatest attitudinal barrier for immigrants and migrants is their negative attitude toward people living with HIV and AIDS. There is no strong dislike of condoms *per se*, but condoms are associated with the very negative attitudes that are held by many migrant and immigrant communities regarding homosexuality, promiscuity and drug use. To overcome these, a campaign might be created which seeks to disassociate condoms and safer sex practices from homosexuality, promiscuity and drug use.

For example, a possible prevention program might associate condom use with many positive attitudes held by different migrant and immigrant communities, such as with caring for one's partner, family planning, and reducing STDs. The more formidable task of reducing stigmatization of homosexuals and promoting support for drug abuse programs and drug users might be a longer-term goal.

Positive attitudes toward unprotected sex might be tempered by knowledge of the potential risk. A bold strategy would promote non-penetrative substitutes and safer sex negotiations with regular partners in which mutual testing and negotiation are prerequisites for unprotected intercourse.

B. Normative Framework: Prevention Suggestions

All migrant and immigrant participants reported that their community norm was to practice unprotected sex. Only the several gay immigrants who associated more with the gay community than others from their own nationality reported a norm of safer sex.

One approach to changing the norm is to use important interpersonal networks. For example, since all groups noted the importance of friends, a potential strategy might be to establish contacts with community leaders or within networks of men and women and to promote peer education within these

networks. Notably, this strategy should be different for younger immigrants and migrants, who tend to associate more outside of their ethnic community.

Families were identified as a weaker source of information than friends for all immigrant groups, although migrants considered the two to be equally important. Most participants said they were reluctant to talk to their parents or children about sexuality or drug use. This suggests that families would not be particularly effective targets for prevention interventions.

Mass media can be an effective way to set the agenda for immigrants and migrants, particularly those who have low literacy or do not read the available brochures and pamphlets. Cable TV and native-language newspapers are used frequently by these populations, and HIV prevention messages could be effectively distributed by newspapers and local television.

Care providers are the main source of HIV prevention information for selected immigrant and migrant populations, according to Jamaican, migrant and South American MSM participants. Similarly, Haitian, Dominican, South American and migrant participants also identified CBOs with strong infrastructures as important sources of information. Haitian, Dominican and Chinese participants reported a strong infrastructure of spiritual healers and herbalists. Therefore, providers and CBOs can be effective HIV prevention educators if they have culturally correct messages. Additionally, outreach to alternative medical sources, to provide them with HIV prevention material and advice, could make them a potential avenue of education as well.

C. Structural Framework: Prevention Suggestions

Several of the immigrant and migrant populations reported a belief that they would lose their jobs if they asked about AIDS and if they were perceived as being HIV-infected. This suggests that there should be collaboration with employers to provide assurances to immigrant and migrant employees that HIV/AIDS prevention information can be accessed without any negative impact on employment or housing.

As HIV infection was not protected under the Americans with Disabilities Act (ADA) until very recently, in many instances, the perception of discrimination may have been correct. Without assurances that there will be no discrimination, or means to address discrimination, immigrants and migrants may continue to avoid venues and sources of HIV prevention information. Advocacy for protection against discrimination or clear rules regarding confidentiality could lead to assurances that there will be no discrimination, and this would encourage more persons to seek HIV prevention information.

Recent legislation has affected who may obtain benefits, including entitlements to health care. Immigrants are cautious about revealing HIV status or other issues that would alert them to authorities or otherwise jeopardize their status.

D. Personality Framework: Prevention Suggestions

The reported sense among women and immigrants that they lack self-control was less than was anticipated. Except for the Chinese men, there was a sense of self-efficacy. In the focus groups, some Jamaican and Dominican women suggested that some women do not have a say in their sexual decision-making. As suggested above, greater partner negotiation skills could encourage a greater sense of

empowerment about adopting safer practices. Structurally, advocating greater resources for the female condom and the development of effective viricides could lead to greater empowerment by women and thus lead to safer sexual practices as well.

While fear may motivate behavior change, among migrants and immigrants, programs that use heavy-handed fear of HIV/AIDS are more likely to increase a sense of fatalism that, in turn, will contribute to the continuation of unsafe practices. While the theory suggests that raising anxiety levels may lead to adopting safer practices that are acceptable to the community and individuals, these must be accompanied by education about safer practices.

While the moderators of the focus groups did not draw out discussions about the need for love and intimacy, some immigrant and migrant participants did express the need for intimacy from their partners. Thus, programs might be developed that dwell on this positive aspect of sexual interactions and associate safer practices with an expression of love and intimacy.

Overall, the findings from this project suggest strategies for community HIV/AIDS educators and service providers on how to focus on information, as well as on normative, structural and personality factors that are related to adopting safer practices for different immigrant and migrant populations. It is hoped that the distribution of these findings will sensitize educators and providers to a variety of legal and social factors that prevent immigrants and migrants from seeking the HIV/AIDS primary and secondary prevention services they need.

Finally, these recommendations suggest the uses of interpersonal, mass and small media for prevention education, as well as community interventions. Several suggestions are made that emphasize the interaction between the individual, his or her partners and the community at large. Effective HIV/AIDS prevention will become possible through the utilization of existing communication networks and emphasis on factors that the project participants identified as contributing to adopting safer practices.

BIBLIOGRAPHY

Fiske, S.T., and Taylor, S. E., *Social Cognition*. New York, Random House (1984).

Heider, F. (ed.), *The Psychology of Interpersonal Relations.* New York, John Wiley (1958).

Memon, Amina, "Perceptions of the AIDS Vulnerability: The Role of Attributions and Social Context," *AIDS: Responses, Interventions and Care,* Peter Aggleton, Graham Hart and Peter Davis (eds.). London, Falmer Press (1991).

Mikawa, J.K.; Morones, P; Gomez, A.; Case, H.; Olsen, D.; and Gonzales, M., *Hispanic AIDS Survey.* Abstract No. M.D. 4007 presented at the International Conference on AIDS, Vol. 7, No. 1, p. 391 (1991).

Bronfman, M., and Minelo, N., *Sexual Habits of Temporary Mexican Migrants to the United States of America: Risk Practices for HIV Infection.* Abstract No. PoD 5219 presented at the International Conference on AIDS, Vol. 8, No. 2, p. D423 (1992).

Battle, R.S.; Cumming, G.L.; Yamada, K.A.; and Krasnovsky, F.M., "HIV Testing Among Low-Income African-American Mothers," *AIDS Education and Prevention*, Vol. 8, No. 2, pp.165-175 (April 1996).

Organista, K.C.; Balls Organista, P.; Garcia de Alba, J.E.; Castillo Moran, M.A.; and Ureta Carrillo, L.E., "Survey of condom-related beliefs, behaviors and perceived social norms in Mexican migrant laborers," *Journal of Community Health*, Vol. 22, No. 3, pp.185-198 (June 1997).

Deren, S.; Shedlin, M.; and Beardsley, M., "HIV-Related Concerns and Behaviors Among Hispanic Women," *AIDS Education and Prevention*, Vol. 8, No. 42, pp.335-342 (August 1996).

Cohen, M., 'Changing to Safer Sex: Personality, Logic and Habit," *AIDS: Responses, Interventions and Care, supra*, at pp. 19-38.

Cohen, M., "The Place of Time in Understanding Risky Behaviour Related to HIV Infection: Inter-Generational Values, Current Trends and the HIV Epidemic," *AIDS in Europe - The Behavioural Aspect, Vol. 4: Determinants of Behaviour Change*, Friedrich, Dorothee, and Heckmann, Wolfgang (eds.), (1994), pp. 27-32.

REALITIES OF HIV PREVENTION FOR MIGRANT WORKERS

Migrant farm workers are an ethnically heterogeneous group of individuals who are employed on a seasonal basis for agricultural labor. Traditionally, these workers make their home base in the southern zones of the United States, Haiti or Latin America and migrate northward – "upstream" -- each winter. Some find work "downstream" upon returning home, but, for many, the upstream seasonal work constitutes the sole employment and, therefore, the income for the year. Some farm workers are recruited seasonally by "crew bosses" who are commissioned by upstream farmers. Some return to the same locale every year, but the majority of people migrate north through one of three geographic areas -- eastern, mid or western United States -- to new harvest sites.

There are an estimated 20,000 – 30,000 migrant farm workers in New York State. The population in upstate New York in 1996 mirrored fairly closely the national profile: Mexican and Mexican American, 62%; Haitian, 15%; Black Americans and Jamaicans, 11%; Puerto Rican, 9%; and others, 3%. The migrant labor force is made up of large numbers of single men. Families, including women, adolescents and the elderly, come in smaller numbers and are highly variable between seasons.

The daily existence of migrant farm workers reflects their migrant status, indigenous cultural mores and the physical environment in which they work and live. Working conditions are stringent, wages are low, benefits are non-existent, and bad weather and harvest times are unpredictable. Migrants arrive prepared to start work and often sit idle and unpaid for weeks. Reluctant to voice complaints about working conditions for fear of loss of employment and "blacklisting" among local farmers, they tolerate conditions that would be clearly unacceptable to a majority of workers.

Migrant workers are not routinely excluded from the social service system in NYS, but they may be unaware of the benefits available to them under Medicaid, Child Health Plus or the Prenatal Care Assistance Program (PCAP). As a result these workers may lack a safety net. Migrant workers, even when they are legal, are excluded from some U.S. Labor Laws. Statutes that aim to protect health and to improve working conditions originate from a multitude of agencies which may affect their enforcement. The NYS Department of Labor indicates migrant workers are covered by unemployment insurance if the farm qualifies, and by minimum wage laws under certain conditions. Many non-English speaking migrants are unaware of basic rights they do have regarding wages and compensation. Migrant workers who are illegal immigrants live with the fear of unannounced INS raids that leave them very vulnerable to expulsion from the United States. However, recent reports indicate that many New York State migrant farm workers (up to 80% in some reports) are United States citizens migrating from states, such as Florida and Texas.

Even with some social and legal protections, these workers are often subject to the whims and demands of their employers. Adverse working conditions, residential migrancy and poverty lead to a variety of health problems and psychological stresses for this population.

Within this context, ethnic groups of migrants approach health in unique ways. Attitudes toward health are a combination of folk rituals and Western medicine. Preventive medicine, the concept of disease as a logical function of exposures and behavior activities, may be unknown. For these reasons, any health education of migrant farm workers must allow for this. The scientific principles of cause and effect must be integrated with culturally specific models if there is to be any hope of inducing changes in disease-producing behavior.

Migrant-specific health services are available throughout New York State in areas with the highest concentrations of migrants. Often affiliated with community health centers, these migrant health programs may receive federal funding and often work in partnerships with county health departments and other non-profit agencies to provide disease-specific health care, supplement surveillance work and provide continuing care. In New York, outreach workers in Migrant Health Programs have had success in helping migrant workers access health care and social services such as food stamps, Medicaid, prenatal care and Child Health Plus.

Barriers to health care for migrant farm workers are not simply a function of inadequate access. This part of the report details the culture of migrancy, ethnic-specific subcultures and the effect of both on social functioning, health and risky behavior, awareness and understanding of HIV infection. This information was obtained through focus groups and years of agency experience with these populations. The migrant work and lifestyle is described, as well as information on housing, transportation and health. This insight into migrant life is intended to educate those working with migrant farm workers about the commonality of culture.

I. THE CULTURE OF MIGRANCY

Migrant farm workers live and work in rural areas with few services. Services which are available generally target the year-round, non-ethnic populations of the community. Few farm workers have access to the entertainment and commercial establishments available in regional population centers, where health care services are usually located. Although crew bosses offer transportation to health care centers, workers are reluctant to leave the fields, which can result in a loss of income. In addition, workers greatly fear discrimination if they seek help for work-related injuries. In a 1994 survey of 3600 migrants in upstate New York, over half reported that they had no dependable means of transportation out of the migrant camp (source: Pat Rios, personal communication).

The isolation that many migrant workers suffer is also cultural. Migrants are of multiple ethnicity and languages. In large population centers, entertainment is often available in multiple languages. By contrast, in rural areas, entertainment is generally limited to radio and television and, while there may be limited access to a bilingual radio station, that language is usually Spanish. A recent survey found that over 90% of U.S. households own a television (source: *The New York Times*, April, 1998). Clearly, television is a major informational source and a significant vehicle for public health campaigns. It is one of the most effective methods of communicating information to a semi-literate population. The lack of multilingual television greatly hinders community health education efforts.

In addition to a lack of stability and adequate social supports, migrant workers also face economic deprivation, which creates serious health, social and educational problems. The culture of migrant farm workers is a culture of poverty. Their income is well below the national poverty guidelines. The majority of farmworkers earn less than $7,500 annually. Although wage rates for farmworkers increased during the last decade, when adjusted for inflation, farmworkers' wages decreased by 5 percent (National Center for Farmworker Health, 2000). Migrant workers, including legal immigrants, are entitled to receive traditional government social supports that are offered at this income level. However, farm workers supposedly receive adequate wages for their seasonal sustenance when work is available, and they are, therefore, ineligible for assistance benefits, in spite of the fact that the income they receive seasonally must suffice for the remainder of the year, when work is unavailable.

Clearly, the migrant life is arduous. Non-profit and government agencies do assist in resettlement. They help with job training, finding permanent employment and learning the English language. Government agencies provide farm workers' children with education specific to the migratory lifestyle. Change, however, is difficult. Most migrant farm workers have known one lifestyle since childhood. Resettlement into a provincial, white community has its own inherent stresses.

Migrant farm workers often have little control over their work or home environment. As a result, some migrants believe there is little they can do to better their personal health or social circumstances. To many migrants, harm reduction is not a familiar concept. Moreover, some folk cultures view disease in terms of inherent good and evil rather than as alterable and related to external exposures. While many migrants know that there are adverse occupational exposures or deficiencies in their home environment which cause illness, some feel powerless to make changes to protect themselves. This reluctance presents challenges for educators who try to encourage behavioral changes. Community educators must understand the subtleties and demands of both the migrant farm workers' lives and their cultures when designing effective educational programs.

II. HOUSING

Migrant workers are, by definition, working away from their homes. Often unable to speak the language of the places where they work and having limited resources, they have few options but to stay in housing that is made available to them at the work site. Camps in which migrant workers live are sometimes in remote locations and few workers have cars, which leaves them little access to commercial conveniences.

According to the National Center for Farmworker Health (2000; Website: http://www.ncfh.org/aboutfws.htm) housing is a serious problem. Temporary housing for farm workers has been traditionally met by growers through labor camps. Some employer-provided housing does exist. However, attempts to enforce housing standards have created a trend toward employers' discontinuing housing. Private housing is not federally regulated. Private housing tends to be substandard and expensive. While some hired farm workers live in well-kept housing, most housing is deficient, crowded and unsanitary. In addition, migrants often lack safe drinking water, bathing and laundry facilities, and adequate sanitation.

New York State monitors migrant farm worker housing on a regular basis, so housing in NYS may be better than housing available in other states. Prior to 1997, the standard in NYS was one toilet and shower for every 15 persons. After 1997 that ratio went down to 1:10. While most camps in NYS have water supplied to the buildings, the water supply for some camps comes from an outside faucet and serves several families. In 1997, NYS surveys showed that only 52% of camps had mechanical washers. Washing facilities are critical to help adequately rid farm workers' clothing of pesticide residues.

In NYS, regulations relating to migrant housing and public health are actively enforced by local health departments. However, the costs of compliance, from the perspective of small farmers, are burdensome. If the costs of upgrading the housing exceed the benefit to them, they will opt to close the camp rather than make the necessary repairs, in effect compromising the welfare of the workers even further by leaving them jobless as well as homeless. A federal initiative to relieve the financial burden to farmers through low-interest loans for the construction of more modern facilities has helped to alleviate this situation somewhat, and with increased pressure from regulatory agencies, it is likely that conditions will continue to improve.

III. HEALTH

Migrant farm workers are recruited for crews or hired by farmers based on their health. The "healthy worker selection process" is a natural selection process whereby healthy workers are the ones who make it to NYS as part of the East Coast Migrant Stream.

Many of the health problems found in the general population, particularly among minorities and the poor, affect migrant farmworkers. Experience from the 14 migrant health sites funded by the NYS DOH shows that almost 50% of the conditions treated are infections, respiratory conditions, muscular-skeletal conditions. Untreated dental conditions have been noted as an important area of need. In many cases, the frequency or intensity of a health problem is greater within the migrant population than is the population at large. Some health concerns are clearly attributable to the occupational hazards of farm work. Dermatitis and respiratory problems are common. Lack of safe drinking water contributes to dehydration and heat stroke. Depression is common among migrant farmwokers. It is often related to isolation, economic hardship, and weather conditions. Poverty, stress, mobility, and lack of recreational opportunities make migrant farm workers especially vulnerable to substance abuse. Conditions such as tuberculosis, diabetes, cancer, and HIV, which require careful monitoring and frequent treatment, pose special problems for migrants who must move frequently (National Center for Farmworker Health, 2000; Website: http://www.ncfh.org/aboutfws.htm).

HIV infection is of increasing concern among migrant farm workers throughout the country, as migrants are at high risk for a variety of reasons, including frequent utilization of sex workers. As noted earlier, HIV prevention media campaigns often do not reach this population. Additionally, high illiteracy rates, language barriers and adherence to folk medicine traditions are significant barriers to HIV prevention education. Although there have been few studies to determine the prevalence of HIV among migrant farm workers, one recent review of HIV disease among this population in the United States found prevalence rates varied between migrant groups and ethnicity, from 0% in Latino males in the western stream to 13% in a group of single African American males in South Carolina. The highest rates were found to be among farm workers who migrate northward from Belle Glade, Florida, the migrant epicenter of AIDS. In addition, higher rates were found among U.S.-born migrants than those who were foreign-born [source: Organista, 1997). HIV surveillance among this population would be difficult at best, because of the large numbers of illegal immigrants who resist participation in any medical tracking operation, and any figures reported must generally be assumed to be unrepresentative of the true prevalence of any illness. In upstate New York, where screening has been conducted since 1993, initial numbers of migrants tested were very low. However, 627 migrants were tested between 1995 and 1997, and the average prevalence rate over that three-year period was 4% (source: Finger Lakes Migrant Health Center Program, 1995,1996,1997).

More than 50 years ago, the Government attempted to address the problem of high disease rates among migrants by developing a system of health services specific to migrant farm workers. Unfortunately, efforts have been inconsistent. Health care funding for farm workers was first provided in 1946 through the Department of Agriculture's Farm Labor Program. Although more than 100,000 workers received health care services through this Program, Congress aborted the funding within a year. Specific funding for migrant health services was not reinstated until 1962, when the Migrant Health Act authorized delivery of primary and supplemental health services to migrant and seasonal farm workers with an initial appropriation of only $750,000.

While funding has increased over the years, it has not kept pace with the rate of health care inflation. The 1993 appropriation was $57.3 million, which covered health care services for over 500,000 migrant and

seasonal workers and their families at more than 400 clinic sites across the Country (source: Gaston,1992). Although this sounds extensive, it only provides an average of $100 per migrant, for services which cover only about 15% of the total migrant and seasonal farm worker population. The remaining 85% of workers utilize health care services more traditionally used by poorer populations of this country, including emergency rooms for non-emergency care, physicians and other health care providers who are willing to treat patients under cost for routine care and no care at all other than in absolute emergencies.

It is evident from the above that migrants experience multiple physical and psychological stresses which negatively impact on their health, including language barriers, lack of transportation and financial resources, unfamiliarity with the American health care system and the lack of time. Health centers, which provide care to migrants, attempt to address these issues through outreach and the use of multicultural, multilingual health center staff, as well as in-camp screening for chronic health problems.

As noted earlier, however, preventive health care is an unfamiliar concept to most migrants, as is the concept of "public" health. Moreover, prevention of chronic illness, such as breast or cervical cancer and preventive dentistry, require continuity of care and migrants are, by definition, transient and worrying about the logistics of daily survival. Furthermore, many of their illnesses are the result of their work and working conditions and cannot be prevented in an economically viable manner. As a result, migrants commonly wait until illness is at a critical stage before they seek medical help. Many who come from Third World countries see hospitals as a place to go to die. Health centers are unfamiliar territories. The migrant patient, upon entering the clinical setting, is stepping into a system whose technology is in deep contrast to the village "curandera," whose teas and herbal and folk medicines are more familiar. Misunderstandings abound in the patient-doctor interaction, which often result in medical non-compliance and failure to follow up.

Migrants are often illiterate and ashamed to admit this to health care providers who, almost invariably, come from different socio-economic and cultural backgrounds and who are increasingly under time and money constraints. Health care that is tailored to suit a migrant farm worker's lifestyle requires time and an interest in the patient. Misunderstood, migrants will return to their familiar mode of "crisis medicine." Attempts at preventive care will fail.

Migrant health programs have addressed the conflicts and gaps between the needs and resources of farm workers by attempting to create links with other farm workers, with whom they will be more comfortable and familiar. Resettled and current migrant farm workers have been recruited to serve as intermediaries and to outreach between the health center and the workers. These lay health workers (LHWs) function as traditional community health workers, offering focused health education and facilitating the use of health care services. They are instructed in basic nursing skills, such as methods of vital sign reading, interpretation of PPD's, HIV pre- and post- test counseling, administration of medications prescribed by licensed health care providers, child care and first aid. The trained LHWs promote awareness of these disorders and educate other farm workers about ways to identify, prevent and treat them. As outreach workers, they may also conduct surveillance of local populations for specific disorders, and their outreach roles have evolved into case management, which enables them to help farm workers negotiate the American social and health system. Once coordination of health care between the migrant camp and the local health care facility is established, public health agencies can also be linked across streams. To be truly meaningful, this work requires ongoing, repeated in-camp follow-up throughout the harvest season as well as coordination with other health care providers across the stream once the farm workers leave the area, either in advance (if the next work location is known prior to departure from the area) or after the

migrants reach their new sites. The justification for such individualized health care is obvious, both for its public health ramifications and for the need to provide adequate health care for a population with inadequate resources to obtain health care services for itself. Unfortunately, few programs have the financial resources to offer the intensity of such case management, and only a small percentage of migrants are provided such services.

> "Do migrant farm workers need such resource intensive care to effectively negotiate the U.S. health care system? Probably, if care is to be modeled on U.S. standards and models. Resources, however, could perhaps better be spent on culture-specific health education, which serves larger numbers. Educational programs have been developed which target Mexicans and Mexican Americans, particularly regarding prenatal care in both method and content. Similar programs can, and are in the process of being developed for diseases with epidemic potential, such as HIV infection and tuberculosis" (source: Bletzer, 1995).

Culturally-specific programs are designed with the use of ethnographic data, which can be obtained through key informant interviewing, surveys or in focus groups which are conducted in the language spoken by the farm workers at a site within their community. Data is collected on risk factors for disease exposure, as well as awareness of the disease and its potential impact on health and work. Effective use of this data has been made to produce educational programs which, at a minimum, have resulted in improved understanding of disease and at best, changes in behaviors that can result in transmission or acquisition of illness.

IV. FOCUS GROUPS

Five focus groups were held between October, 1996, and January, 1997, to collect information on ethnic-specific knowledge of HIV infection and AIDS among migrant farm workers. Participants included seven Haitian males, five Haitian females, five Jamaican males, five African American females and five African-American males. Although several of the Haitians and all of the African Americans had settled permanently in the area and were not "true" migrants, nevertheless, they shared a culture and worked with the migrants during the harvest season. Jamaican women were not in the area as Jamaican males travel upstream alone. Outcomes of four of these five groups are reported below. The fifth group, African American males, did not yield sufficient information to report.

The focus groups were conducted in order to obtain information about relationships and family, sites of socialization and knowledge about health in general and HIV disease in particular. The goal was to obtain information which could be utilized to offer more effective and personally-targeted education about HIV infection and AIDS.

Each participant was asked to complete a written questionnaire about his or her social activities, health and HIV infection, which was designed to elicit the following information: How do these workers face issues of personal health risk, control and relationships? Are their attitudes primarily formed by their status as migrants? To what extent does their ethnicity influence their social behavior? The answers can be

reviewed from both perspectives, as migrant beliefs and attitudes actually reflect both the influence of migrancy and the culture of the home country.

The questionnaires were completed after each focus group with the help of the moderator, as the majority of the participants had limited fluency in English. It is important to keep in mind that migrants are not accustomed to a solitary existence, but that group socializing is the norm among this population. However, the apparent openness observed in group settings does not translate into openness about personal health and sexual habits. Peer acceptance is the dominant force when information on sensitive issues is discussed in public. Due to time limitations, the questionnaires were answered verbally, in the group setting. Thus, although they, optimally, would reflect the most accurate information, the accuracy of the information obtained about personal habits must be somewhat suspect.

V. RELATIONSHIPS AND CONCEPT OF SELF

Among the focus group participants, work companions were also social companions. Workers lived together in camps or apartment complexes where everyone was considered "family." The social networks they developed during the harvest season were derived from the camps in which they were living and working. Different ethnic groups were often mixed at these housing sites, with African Americans, Jamaicans and Haitians sharing the living space. Cultures were shared through music and food. One of the African American women was married to a Jamaican man, and the father of the child of another was Haitian. The social support network was particularly strong among the female migrants. *"We are our own family,"* explained one of the women, *"since we do not have much family up here."* The women helped each other through crises by sharing food, watching each other's children, and generally "looking out for" one another. They spent most of their leisure time with each other and friends from church. The Jamaican and Haitian men stated that they "hang" together on a daily basis, when they were not working. Alcohol was a strong component of Jamaican socializing, but it was used minimally by the Haitians. All focus group participants vigorously denied intravenous drug use.

The majority of non-Hispanic migrants travel as single men. As noted previously, many of the African Americans and Haitians were resettled rather than "true" migrants. Promiscuous sexual behavior, however, does not seem to correlate with true migrant status. Rather, the majority of Haitian and Jamaican men acknowledged that they had one main sexual partner. However, while five or six Haitian men admitted that they had sex outside of their relationships, the Jamaican men stated that they were faithful but were unsure as to the activities of their women. The African American men as a group had no primary partners, and the number of sexual partners they had in the past two years varied across ethnicity and ranged from zero to five in number. In the past, the single men reported, they regularly used female sex workers. However, the men evaded the issue in the focus groups, and the degree to which this custom persists is unclear.

The women interviewed were suspicious about their partners. The African American women were all resettled migrants, while the Haitian group was split. Trust is a prominent issue for these women. One stated the men tend *"to graze on other grass,"* while another stated that, *"If you know your mate, you know whether he is lying or not."* A level of acceptance regarding infidelity appeared to be inherent in the Haitian culture. While women are supposed to be responsible for raising and supporting their children, men are freer to *Trennen zei* (roam) and to have multiple partners. However, this does not imply that these women are monogamous themselves. Haitian women spoke in the focus group of *cache lavi* (prostitution; having to find a man) to make ends meet.

Among the Haitian men, control was a big issue, central to the sense of self. To be in control was to be centered. Control was internal, but it could be affected by external sources, such as recreational drugs or intoxication with alcohol, and, since such things could make them vulnerable, the men avoided them. Additionally, the Haitians viewed women as being in charge in bed, and they believed that manipulation by the women could be avoided in part by strict limitations on alcohol intake and through hard work. Throughout the focus groups, participants emphasized that they were in New York to make money and work at remaining healthy. By actively working and making money, they kept women *"off their backs"* and were able to send money back to their families. Good health was of great concern, as the ability to work and to maintain a standard of living depended on it. When prompted to describe the health problems of greatest concern to them, four out of six Haitian men responded "money." Haitian females echoed the belief that they are in control, along with their men.

Although less clearly articulated, Jamaican men voiced similar concerns about the negative consequences of losing control. However, for Jamaicans, premeditated caution seemed rare, as socialization was often associated with heavy drinking and ultimately unrestrained behavior. There seemed to be some understanding that caution was decreased even further when they were intoxicated. There was an overlay between the loss of inhibition from drinking and the possible spread of AIDS from the act of drinking. *"Drinking won't spread it if we don't pass the cup between each other."* This is discussed further below.

VI. HIV KNOWLEDGE AND AWARENESS

These migrants were aware of HIV infection and AIDS and its serious implications. HIV infection was viewed as a relative unknown; AIDS was a dreaded disease. For the Haitian men, AIDS meant evil and death. *"I will go to the doctor and wait for death to come. If I am positive, I will go to hell. So I will go to church."* The Jamaican men were more optimistic, although it should be noted that only one had tested positive that summer. The men all spoke with hope about how they would approach their infections if they were to become infected. Fighting for health was a universal approach, as was looking for cures. Trying to find some spiritual *"opposition,"* the men viewed traditional, Western medicine as relatively useless. *"Science"* does not have the answers. *"God, religion, perhaps."* The AIDS epidemic was a topic of great interest among the African American women, who thought of AIDS as a very dreaded disease, *"a grim reaper."* HIV and AIDS was not a major personal health concern to the Haitian women, however, although all of them had at least a basic understanding of the modes of transmission of the disease, as well as of risk factors and the progression from HIV to AIDS. The level of understanding varied with the age of the participant and her level of fluency in English. All were very aware of the stigma associated with the presence of AIDS in their community. It is like *"maladi lamo"* (kiss of death). One of the women said she would rather kill herself than live with AIDS, and another said, *"I would eat myself to death."*

The acknowledged origins of HIV disease varied widely among the different ethnic groups. This may be attributed in part to the level of exposure to health education messages in the American media, which in turn correlates with the level of integration into the local culture. The Haitian men, who strongly maintained their cultural identity and associated superstitions and folk beliefs, attributed HIV infection to disobedience and professed fatalism about HIV disease (*"If you're going to get it, you're gonna get it. You got to be careful."*) The issue of control was clearly linked to HIV transmission, and ejaculation was the embodiment of control (*"You can have sex, but if you don't come, you don't have risk.")* Yet, the men also voiced an understanding that condoms were protective if used properly. The women stressed that *"se ou mem ki pou kembe tet ou"* (each one is responsible to protect oneself). They regarded AIDS as a curse *("se you maiediksoyon 1i ye")* of modern times.

Filth and degradation, rather than fear, were the chief connotations of HIV infection and AIDS for the Jamaican farm workers. AIDS is caused by "germs" and "dirty" blood *("If you're poor and in the hospital, you can get it from blood.")* Although not articulated directly, sexual intercourse did not necessarily lead to HIV transmission. The need for self-protection was understood and, here again, if the men were in sufficient control, they could reduce their risk *("Don't suck cause you suck germs.").* Proper condom use was an accepted way to reduce risk *("You got to hold it to a certain level. You got to know how to use it. If there are germs there you could get it if you don't use it right.").* As mentioned previously, however, premeditated caution among these men was rare.

The link between promiscuity and unprotected sex and sexually transmitted diseases other than AIDS was universally understood by all the men, regardless of their ethnicity. The mode of transmission of the disease however, was not as clear. Haitian men described the symptoms of an STD as *gran chaleur,* which comes from *"sitting on a cool flat surface for a long time."* The women were less well-educated about STDs. The Haitian women did identify sexual transmission with syphilis and HIV. However, two women noted that "*women die faster than men from the disease because they lose blood during menstruation,"* and that handsome men were more likely to contract the disease because they attracted a larger number of female partners. Yet, there was no clear understanding of what comprised "risky sexual behavior." None admitted to the practice of risky behaviors, yet none used condoms during sex, although they stressed their personal responsibility to protect themselves from the disease.

Folk beliefs were also implicated in the spread of these diseases. A jealous *matiot* (mistress) was responsible for sending *chank* (STD) through her lover to his wife. African American women associated the disease with evil (It is *"people-sent"; "God is involved"; "It is God against Satan and one will win"*). There was ample proof, according to one woman, that *"the Bible speaks of it. It is the fulfillment of prophecies."* Others viewed AIDS as a conspiracy (It *"comes from chemicals"* which unintentionally *"got out of hand").* The intervention of this higher authority contrasted with their professed belief that condoms would protect against the virus. Control was important, but not sufficient to fully protect, because, *"Sex is one of the best things in life,* and it plays an important part in their lives, keeping them *"still alive, not dead."*

VII. SOURCES OF INFORMATION

Participants believed that HIV disease is prominent in today's media, and that television, in particular, is a consistent source of information about the causes of infection, risk factors and how to avoid them, and it can dispel myths. Outreach workers and the church reiterate these health messages. However, friends were considered to be the most trustworthy source of information. The Haitians believed that the language barrier inhibits their knowledge, as there is little information about HIV or AIDS written in Creole or broadcasted in Creole. Although there is a Haitian radio station, the information it spread was not clearly reliable. Rumors were spread. ("*A doctor can give you a shot and kill you";* and *"All this talk of AIDS is an American plot to keep Haitians out of the Country.")*

Physicians and clinics were also believed to be important educational providers. The women in particular wanted more educational programs. From these, one woman learned, *"don't mess with people you don't know. "*Others stated: *"Mache* (behave) *differently. Use condoms. Take fewer chances. When I see a woman trying to come near me now, I want to run from her."*

All migrants wished to increase their level of knowledge about HIV infection. Meetings about AIDS, more literature and groups such as the focus groups were welcomed. Illiteracy was common, and, although pamphlets were considered helpful, all participants thought they would be more useful if they contained pictograms.

VIII. SUMMARY

In brief, migrant farm workers are a multi-ethnic group with a unique culture. Their lifestyles form and are in turn formed by both the occupational and non-occupational experiences, and their health, which is poor, is greatly influenced by these experiences. They suffer from high rates of sexually transmitted and infectious diseases, the latter of which are attributable to poor sanitation. Health care is inconsistent. To work is to eat; only when illness impairs the ability to work will most farm workers seek treatment. Prevention of future illnesses is a luxury for which few have the time or can make the effort.

Most migrant workers are aware of HIV, its potential lethality and its transmission through blood contamination and unprotected sex. Across ethnic groups, promiscuity and HIV infection were clearly linked, yet folk traditions overlay and influenced self-protective behavior, as did ethnic social habits and the concept of self. Haitians focused on "control" and believed that sexual temptation and "disobedient" behavior can be averted through hard work and abstention from alcohol. Jamaicans believed that cleanliness and the avoidance of germs could protect them from HIV infection.

The lack of formal education also influences the way farm workers receive and process new information, including health-related information. Trusted sources include other farm workers, physicians and outreach workers and the church. Media messages for HIV are targeted to specific populations, but these multilingual messages are rarely available in the rural districts where migrant farm workers live and work. HIV education for this group should combine information obtained about social and work habits with the well-tested community education methods. Effective strategies should focus on the development of risk-aversive behaviors within the context of the migrant lifestyle. If the messages are transmitted through community health workers and are reinforced up and downstream, it is likely that the rates of HIV transmission will decrease.

BIBLIOGRAPHY

1. Bletzer, K.V., "Use of ethnography in the evaluation and targeting of HIV/AIDS education among Latino farm workers," *AMS Education and Prevention*, Vol. 7, No. 2, pp.178-191 (1995).

2. *Executive Summary: A study of housing for migratory agricultural workers.* InterAmerica Research Associates (1978).

3. *Annual Report*, Finger Lakes Migrant Health Care Program (FLMHCP), 1995.

4. *Annual Report*, FLMHCP (1996).

5. *Annual Report*, FLMHCP (1997).

6. Gaston. M., "Testimony to the Commission on Security and Cooperation in Europe," *Migrant Farm Workers in the United States*, U.S. Government Printing Office (1992).

7. Interstate Migrant Educational Project, *Interstate Migrant Educational Task Force: Migrant Health,* Education Commission of the States, Denver, Colorado (1979).

8. National Center for Farmworker Health, Website: http://www.ncfh.org/aboutfws.gtm; pp. 2-3, 5-6, (2000).

9. Organista, K., and Organista, P.B., "Migrant Laborers and AIDS in the United States: A Review of the Literature," *AIDS Education and Prevention*, Vol. 9, No. l, pp. 83-93 (1997).

10. The New York Times, April, 1998.

11. Wilk, V., *The occupational health of migrant and seasonal farm workers in the United States,* Washington, D.C., Farm Worker Justice Fund (1986).

25 THINGS YOU CAN DO
TO MAKE YOUR ORGANIZATION IMMIGRANT - FRIENDLY

HIV/AIDS service providers like to think their services are open to everyone and that they do not discriminate. But, without intending to exclude anyone, sometimes the failure to understand how different communities view an agency and its services amounts to *de facto* discrimination. The purpose of this part is to offer some tips on how to make your service program more accommodating to the needs of immigrants. This is not meant to be an all-inclusive listing, and each point does not apply to all immigrants. This information comes from the observations and tips of immigrants and immigrant advocates.

1. Become aware of your own "immigraphobia"! One of the greatest obstacles to serving immigrants is our own immigraphobia, or dislike of immigrants. Inside most of us is some level of hostility to the needs of immigrants as job takers, unfair competition and/or people who are "foreign." Despite facts that show that immigrants contribute more to the economy than they receive and without regard to the common humanity we all share, immigraphobia continues to spread. AIDS service organizations have not escaped this prejudice. Advocates and immigrants regularly hear some version of the following complaint:

> "These people come to this country and take services from those Americans that are in need. There are so few resources for AIDS to go around for people who are citizens, these immigrants should be grateful for what they get rather than complaining."

While, sometimes, these words are spoken directly to the immigrant, most often they go unsaid and are manifested by non-cooperative attitudes. For organizations which have chosen to address immigraphobia internally, the use of awareness education has proven successful. While everyone has their personal views on immigration policy, the treatment of immigrants should always be respectful.

2. Recognize that every immigrant is a distinct individual. Conclusions about people that are based on their looks, speech, dress and mannerisms form the basis for countless interactions everyday. With respect to immigrants, most of our preconceptions are wrong. Set out below is a list of variables at work that may help to highlight the individuality of each immigrant:

- **Recent immigrants have distinct needs that are different from long-term immigrants.** Studies have shown that the length of time an immigrant has been residing in the United States dictates the kinds of services (s)he might need. More recent immigrants have the most serious difficulty connecting to needed services because of the difficulty in obtaining employment, the lack of a social services safety net, language isolation, etc. The longer an immigrant is here the more (s)he is likely to be connected to services and social support networks.

- **Some immigrants are committed to becoming American citizens while others are unable to do so.** Some immigrants desperately want to become citizens of the United States but are ineligible for naturalization. Others choose not to naturalize for various reasons. There are immigrants with HIV who remain in this country only because they know that returning to their home country would be a death sentence because of the lack of medication availability. Many

immigrants remain without status or employment authorization and are constantly worried about deportation.

- **Economic class and education levels differ widely among and within immigrant communities.** Just like citizens, immigrants represent every economic and educational background. Some immigrants are functionally illiterate, while others are medical doctors or lawyers trained in their home countries. Some immigrants grew up in middle-class environments while others lived in abject poverty.

- **Immigrants come to the United States for all kinds of reasons.** Some immigrants come for economic reasons, while others are here to be with other family members who have immigrated. There are immigrants who are seeking asylum from persecution because of their political beliefs or sexual orientation, while others are seeking a new life and economic or professional advancement.

3. Learn all you can about the immigrants in your community. An important first step in creating an immigrant-friendly workplace is to understand the immigrant groups in your service area. Get to know the *communities in your community*. The best place to start is to ask a few immigrants about their population, or, as the Latino Commission has found, speaking with ministers in local churches with large immigrant populations. Another resource for demographic information is your local Planning Department. However you proceed, you want to learn where people socialize (that is, where their social clubs, bars, churches and community centers are), about the diversity within their communities (different dialects and regions) and about their critical social institutions.

4. Develop linkages with immigrant organizations in your area for legal and other referrals. Many providers have difficulty in serving immigrants because they do not know where to go for help with questions about legal and home-country issues. Immigrant and legal organizations in your area provide an invaluable link for outreach and referrals on a broad range of non-HIV-related services. By identifying formal linkages with immigrant associations, your organization will better serve your immigrant clients and also provide support to your staff.

5. Ask immigrants only for the information you need. When an immigrant walks through the door of a social service agency, (s)he is taking an enormous step. Unlike other potential clients, many immigrants have a deep fear of "official" organizations, which they perceive as having a tie to government. Concepts such as confidentiality may be completely unknown in their home countries. If there is no specific legislative restriction on a particular service, there really is no need to ask questions that will be seen by immigrants as proxies for asking about their immigrant status. Be very sure that the information is absolutely required by calling such organizations as the Legal Department of the Gay Men's Health Crisis, the HIV Law Project or the Latino Commission. Only ask questions that are necessary. Questions that are often not necessary and can raise anxiety for immigrants include:

- **What is your social security number?** To have a social security number means that you are in the United States with permission from the United States Government. Many immigrants do not have such a number and view such a question as code for "Are you legal?"

- **How long have you been in this Country?** Questions about how long an immigrant has been in the country are seen as shorthand for asking about his or her naturalization status.

- **Why did you come to the United States?** Questions about motive have no place in initial interviews with immigrants. Information about what drove an immigrant to leave family and friends is very personal.

- **What is your immigrant status?** If you have no need for this information, there is no reason to ask for it. It will turn immigrants away from needed services.

6. Ask immigrants for necessary information at an appropriate time. - If you must ask for information that indirectly or directly probes immigrant status (*i.e.*, social security number), it is sometimes helpful to wait until after the basic screening interview. Immigrant status is sometimes complicated, and you will elicit more accurate information from the immigrant if you first establish a basis for trust. Sometimes completing all the needed screening steps before asking for sensitive immigration information will bring a better result. Remember that your first priority is determining the immigrant's needs and then establishing what you can do for them.

7. Do not badger immigrants for information they do not have. If you ask for a social security number and the person says that (s)he does not have one, do not continue to press him or her further. Once an immigrant has told you directly or indirectly that (s)he is not on Medicaid or that (s)he lacks identifying information available to legal immigrants, do not continue to press the point. Do not ruin the trust relationship you have built up by causing further embarrassment.

8. Never assume that an immigrant understands confidentiality. While most of us have specific expectations of confidentiality, for many immigrants the concept of confidentiality of medical records or information is new. In their home countries, there may be little confidence in the willingness or ability of local health providers and social service agencies to keep information private. With this kind of experience, it is important to take the time to explain the procedures your agency or institution follows in protecting individuals' information.

9. Display your receptiveness to different cultures. Many immigrants have reported that they do not feel welcome in many agencies because their culture is not reflected there. They want to feel more connected to an institution that displays cultural awareness and which acknowledges their cultural background. The starting point for addressing the problem is to acknowledge that your workplace reflects the cultural background of the clients served. When you examine the key points of entry to the agency, ask yourself what is being communicated to clients and visitors. If you want to make the first contact more inviting to persons of different cultures, consider adding some elements like decorative arts and cultural symbols from the particular immigrant groups you are trying to reach.

10. Adequate language services are critical in reaching and providing services to immigrants. Despite the widely acknowledged need to provide services in the client's primary language, many organizations still fall far short in meeting this minimal threshold for services. Problems seem to occur when organizations fail to conduct a basic assessment of their language services needs. A well-defined language services assessment will highlight the critical program areas where foreign language-speaking staff should be assigned. If no professional staff is available, a language service plan would identify staff assigned to other areas who could translate or when such helpers as AT&T's Language Line could be used. There is no substitute for hiring trained staff members that speak the language of the program's target populations. To have any hope of reaching immigrants you need to do more than simply offer translations.

11. Do not become exasperated with limited English speakers. Many immigrants work very hard to learn English. Despite their anxiety about speaking English, they often want to make the effort. This can impose a burden on the service provider to understand words that are mispronounced or entirely wrong. Some immigrants report that service providers sometimes become exasperated and even rude when they try to speak English. To avoid the problem, the provider should make a decision as to whether (s)he can, in fact, understand what the client is saying. If not, (s)he should ask politely whether the person would prefer to meet with a native-language speaker to address his or her problems. On the other hand, the provider may decide (s)he has the patience to work with the immigrant and that (s)he is getting accurate information. In this case, the provider is both assisting in developing the self-esteem of a client and in meeting programmatic objectives.

12. Do not assume that immigrants understand what your organization does and the services it has to offer. In many countries, the non-profit system is closely tied to the government, and access to services is dependent on who one's family knows. In other countries, there is no not-for-profit infrastructure and the government provides most of the social services. Because of these varied backgrounds, a provider should never assume that an immigrant client understands what the agency does and its relationship to government. It is better to spend a few minutes with immigrant participants (both in prevention and treatment-related work) explaining the organization, the services it provides and the relationship it has with government. Clarity in the beginning of the relationship will result in better cooperation and more successful interventions.

13. Staff from immigrant communities can be the best form of outreach. One of the most effective tools in recruiting and retaining immigrant clients, and for outreach, is to employ immigrants to assist in developing the program and doing the work. While the immigrant worker should, ideally, come from the same economic and cultural background as prospective clients, an immigrant staff member who is familiar with that segment of society from his or her home country can be a tremendous help.

14. Never make an immigrant feel stupid or like a child. Sometimes when non-immigrants talk to immigrants, a mental age discrepancy gets created. The non-immigrant begins to speak louder and in short words as though the immigrant is deaf and unable to understand English. If the immigrant is deaf, speaking louder will not bridge that barrier. If the immigrant is unable to understand English, speaking in short words may help, but finding a native speaker is probably more effective. Taken together, these behaviors and others serve to infantilize the immigrant. The end result may be that the immigrant does not return or grows hostile in response to such treatment. A better approach is to assume that each immigrant is capable of understanding our slightest nuances of language. If we are wrong, at least we have shown the individual the respect we would want accorded to ourselves.

15. It is important to understand that many immigrants are afraid of being seen by the INS as "public charges." Recent immigration law changes have placed even greater penalties on immigrants who have received some form of public assistance while awaiting citizenship. As a result, although "public assistance" is defined very specifically, many immigrants have come to fear approaching any institution for help. They are concerned that by seeking assistance they are creating a record somewhere that will result in additional financial burdens to their immigration sponsors, or to themselves, or will even ruin their chances of becoming citizens. For some immigrants at risk for HIV, the perception is that even

seeking prevention assistance can be a problem. Some immigrants with HIV infection are even waiting for a "cure" for HIV rather than risk seeking help now and being seen as a public charge.

16. If an immigrant is undocumented, the AIDS service provider and the immigrant may incorrectly perceive they are ineligible for all services. There is both public and private help available to immigrants regardless of their immigration status. Virtually all prevention services in many states, including New York, are open to everyone regardless of their immigrant status. In addition, many support group and other social services can be offered to undocumented immigrants. Before excluding an immigrant from service or promulgating internal guidelines, check with someone knowledgeable about immigration law for guidance.

17. It is vital to understand the basics of immigration law to provide effective prevention, housing and social services to immigrants. Recent changes in federal, state and local social welfare and immigration laws have made the lives of many immigrants much more complicated. Because of these changes, for example, some immigrants are eligible for food stamps, and some for housing assistance, while others are not. You should not be advising or assisting immigrants with their benefits eligibility questions unless you have received training about the recent legal changes on these issues. While no one should expect you to become an immigration law expert, it is important that you be able to spot issues and seek additional advice. As long as you can identify issues of concern and know "what you do not know" you should be able to assist immigrants with HIV in securing needed benefits.

18. Requiring immigrants to discuss their HIV or immigration status in an open setting violates their privacy. Many immigrants have reported being asked about their HIV status and their immigration information in a crowded, open office. While most AIDS service and health care providers are crowded for space, it is important that there be a private room in which to ask such sensitive questions, if they must be asked. Keep in mind that for an immigrant to admit that (s)he is illegal and HIV+ is extremely sensitive and, in some cases, can be the same as admitting to having violated the law.

19. When attempting to recruit immigrants for different programs, specifically mention that immigrants are welcome. Simply adding the word "immigrants welcome" to your literature and materials can do an immense amount to make the immigrant community feel welcome.

20. When planning public education programs, remember that in some immigrant communities there is a stigma in being associated with anything involved with HIV/AIDS. Frequently, AIDS service organizations will sponsor an HIV/AIDS prevention seminar for an immigrant audience and then express surprise that so few people attend. One reason for the poor attendance may be the manner in which the education is being promoted. For many immigrants, there is stigma in attending a health education event associated solely with HIV/AIDS. The implication is that if you attend such an event people will think you have HIV or that someone in your family is a drug user, sex worker or homosexual. To overcome this stigma, it is often easier to broaden the theme of the event to include other health issues. Another item on the agenda might offer an additional level of comfort to the general community and may enhance immigrant participation.

21. The terms, "gay", "lesbian" and "bisexual" are social constructs that may not be applicable to men and women from different countries. In many countries, there is a wide diversity of terms that are used to define men and women who have sex with the same gender. While the term "gay" is increasingly used, it is far from a universally accepted term. In most countries, many people who have sex with a person of the same gender are reluctant to publicly identify with gay-related groups. When dealing

with immigrants, it is important to be flexible in the terminology you use. One recommendation is to avoid the use of the terms "gay," "lesbian" or "bisexual" until the immigrant, man or woman, introduces the term into the conversation.

22. Create opportunities for immigrants of similar backgrounds to talk with each other. Many immigrants with HIV are isolated. Disconnected from their home countries and often estranged from AIDS service providers, they cling to a small network of friends for support. One important role a social service provider can play is to bring these individuals together and give them an opportunity to address their problems as a group. Providing immigrants an opportunity to discuss their own situations and develop responses in a group setting helps empower the community.

23. Remember that you are a service provider concerned with the welfare of your clients. Unless you are otherwise notified by your employer, your responsibilities do not include reporting undocumented immigrants to the INS. In fact, some advocates assert that it is the responsibility of providers to protect the status of immigrants whenever legally permissible. When a single service provider takes it upon itself to act as an INS agent, all programs suffer in lost clients and shattered trust.

24. Immigrant-friendly means using language that respects the humanity of the immigrant. While everyone has grown weary of feeling compelled to use "politically correct" language, the truth is that words can hurt. It is easy to use terminology that does not offend. For immigrants, the word "illegal" usually raises hackles because it indicates that the speaker thinks the person is only a walking violation of the law and that (s)he does not see him or her as a human being. In addition, the term "illegal" is typically wrongly applied because the person using the word does not understand the immigrant's legal status. A preferable term is "undocumented" because it means the person simply lacks the proper immigration papers.

25. Immigrants come in both genders, all races and ethnic backgrounds, sexual orientations and with a multiplicity of languages. If you harbor any racist, sexist or homophobic attitudes, you should either not work with immigrants or learn to set aside those attitudes when entering your workplace.

LEGAL REALITIES FACING IMMIGRANTS

Persons who find out they are HIV+ when they are undocumented, or are in the process of obtaining temporary or permanent status from the Immigration and Naturalization Service (INS), face unique obstacles and fears. Many fear they will be deported if their status is discovered and are afraid of jeopardizing their pending immigration petitions. All are uncertain about what public benefits they can access, if any. As a result of changes in federal immigration and welfare laws, many immigrants are not eligible for public benefits. The non-citizen with HIV has even bigger hurdles to overcome than his or her uninfected counterpart.

The summary which follows is intended as an overview of the current situation for non-citizens who are HIV+. Obviously, additional information, including time limits and workfare, remain for the policy and service planner to consider. What is clear, however, is that immigrants and migrants may not have access to services at precisely the time when knowing their HIV status as early as possible is critically important to make informed decisions about their treatment options.

I. BACKGROUND INFORMATION: IMMIGRATION 101

An immigrant may get permission to stay in the United States, both temporarily and permanently, in a variety of ways. Temporary status includes tourist visas, student visas and temporary employment visas. Permanent status can be as a refugee, asylee or legal permanent resident (also known as "having a green card").

Tourists must abide by the terms set forth by the INS. For example, an immigrant on a tourist visa must leave by the date stamped on the Arrival/Departure Record (the "I-94") in his or her passport and is prohibited from engaging in any employment. Immigrants who fail to abide by the terms of their visas will be removed from the country if and when the INS becomes aware of the violation. Holders of green cards can also be removed for committing a crime that is categorized as "deportable," or if the INS has reason to believe that they have abandoned their United States residence.

A. Green card petitions

The majority of the green card applications approved by the INS each year are family-based, and must be made by persons who are citizens or legal permanent residents. However, only certain family members can be petitioned for, and the length of time until a petition is granted varies in each case. The many ways green cards can be obtained are outlined below.

(1) Immediate Relatives of United States Citizens. A U.S. citizen has the right to petition for his or her immediate relatives, defined under immigration law as a spouse, parent or child under the age of 21. The status of these immediate relatives is extremely important as, under the law, they will not have to wait until a visa becomes available under the quota system.

In reality, however, immediate relatives still have to wait until the INS can process the family petition, and this wait varies with the INS district or consulate that is processing the petition. For example (as of this writing), in New York City, an application for an immediate relative takes approximately two years to complete.

Immediate relatives may reside either abroad or in the United States while their petitions are pending. However, as of January 14, 1998, only those immediate relatives of U.S. citizens who entered the U.S. with the permission of the INS will be able to remain in this country while their petitions are being processed (that is, they will be able to get their green cards without having to go to the consulate located in their home country). These residents will also be able to receive employment authorization while they wait for their green cards. By comparison, immediate relatives who entered this country without the permission of the INS will have to return to their countries of origin in order to complete their petitions for the green card. Furthermore, as a result of immigration reform, an immediate relative residing in this country, who has a petition filed after January 14, 1998, could potentially have a three- or ten-year bar against returning to the U.S. imposed on them when they return to their home country to complete the consular process, depending on the amount of time that they remained in the U.S. unlawfully. (There is an exemption to this provision, as a matter of discretion of the INS. However, much remains unclear about how it will operate.)

(2) Family Preference System. Persons who are not immediate relatives of U.S. citizens will have to wait until visas become available to them under the annual quotas of the Family Preference System. Under this System, when a person petitions for a family member, the petition is assigned a "priority date," which is the date the INS received the petition. This date will be stated in the letter the INS routinely sends to acknowledge its receipt of a petition. Immigrants must wait until their assigned "priority date" is published by the Department of State in the VISA Bulletin to complete the process for their permanent resident visas.

In addition to petitioning for spouses, parents and minor children, a U.S. citizen can also petition for sons and daughters over the age of 21, whether they are single or married, and brothers and/or sisters. However, since these persons do not meet the definition of immediate relatives, they will have to wait until visas become available for them. Presently, sons and daughters of U.S. citizens can expect to wait approximately two years; brothers and sisters of U.S. citizens must wait about 10 years before they will receive visas.

A legal permanent resident can only petition for his or her spouse, children under 21 years of age and unmarried sons and/or daughters over the age of 21. These family members of legal permanent residents are presently waiting from five to seven years to receive their green cards.

Under the Family Preference System, immigrants who are waiting and residing in the United States have no legal protection against deportation and are not entitled to receive employment authorization. (Additionally, as noted above, if their petitions were filed after January 14, 1998, they will have to receive their green cards from the consular of their home countries and may be barred from returning to the U.S. for three or 10 years.

(3) Employment-based visas. An immigrant can also obtain a green card through his or her employer. However, this process is both difficult and costly and will require the assistance of an attorney. The employer must submit a petition to the INS and a labor certification to the U.S. Department of Labor, demonstrating that no U.S. citizen or legal permanent resident meets the criteria required for the job. This certification is required to enable the Department of Labor to review the candidates who come forward to

be interviewed. In general, the higher the skill required for the job, the greater the likelihood that an employment-based green card will be issued. There are a small number of visas available for unskilled workers; however, these are difficult and can take up to 10 years to obtain.

(4) In addition to the above, there are six other ways to get a green card:

a) Registry. A person determined by the INS to have "good moral character," who can also document continuous residence in the United States since 1972, can obtain a green card. Although there are certain criminal convictions which will automatically prevent an immigrant from claiming "good moral character," the interpretation of that term is left to the discretion of the INS officer or judge.

b) Asylee/Refugee status. A person who is granted asylum or refugee-status can adjust his or her status to that of legal permanent resident one year later, if (s)he can show a "well-founded" fear of persecution of one or more of the following types: religion, race, nationality or ethnic origin, political opinion, or because (s)he belongs to a particular social group which is persecuted by the government or by another group who the government cannot or will not control. The only difference between these two categories of residents is that (a) a refugee must complete the process abroad before entering the U.S. with refugee status; and (b) an asylum-seeker can apply for protection once (s)he is in the U.S., regardless of whether (s)he entered on some other type of visa or without permission.

c) Diversity Visa Lottery. Occurring approximately once a year, this program is open to individuals from countries with low admission rates to the United States. In the past, China, the Dominican Republic, Colombia, Mexico, El Salvador and Jamaica have been excluded. To apply for the lottery, persons must (a) be from an eligible country or have a spouse from an eligible country; and (b) have a high school diploma, or equivalent, or job training in a field that requires at least two years' experience. Information on the lottery is published annually, at the same time as the announcement of the lottery program. A person who is selected via the lottery does not win a green card; rather, (s)he is given a chance to apply for one.

d) Cancellation of Removal. Each year, the INS grants 4,000 green cards to people who were previously ordered to be deported. In order to obtain a "cancellation grant," an immigrant will be required to demonstrate (a) that (s)he has lived in the United States for at least 10 years without having received a prior order of deportation; (b) good moral character (that is, has had no major criminal convictions); and (c) that his or her deportation would result in "exceptional and extremely unusual" hardship to his or her citizen- or resident-spouse, parent or child. A cancellation grant is difficult to get because the decision to award the grant is completely left to the discretion of an immigration judge. Additionally, since immigration reform, a numerical cap has been placed on the number of annual cancellation grants, the lower standard of "extreme hardship" has been raised, and the hardship can no longer be shown to the immigrant alone in the absence of other family members. This last change has closed the door for many undocumented immigrants with HIV who meet all of the cancellation requirements except for the qualifying relatives.

e) Domestic Violence and Immigration. There are special provisions under which people who are victims of domestic violence can obtain green cards. An immigrant woman, for example, who can demonstrate that her petitioning spouse (citizen or resident) is physically and/or emotionally abusive, does not have to depend on her spouse to complete the immigration process for

her. This is known as "self-petitioning," and the INS will allow an abused spouse or child to apply under this provision so that (s)he is not required to stay in the abusive relationship simply because (s)he is waiting to receive a green card. There are also special provisions under "cancellation of removal" for battered spouses and children.

f) Special Immigrant Juveniles. There is also a provision under which special immigrant juveniles -- that is, those who are wards of the court or who are placed in foster care -- can apply for green cards, or "J" cards, as they are commonly known. The application process must be completed before the juvenile's 18th birthday.

(5) Other Points to Consider include:

The INS reserves the right to deny immigrants green cards if they fall under any of the many grounds for inadmissibility. For example, the INS can deny permanent residence to someone they believe is likely to become a "public charge" [that is, if the immigrant cannot adequately demonstrate that (s)he will not need public assistance]. Similarly, a person may be denied a green card if (s)he is involved in illegal activity. The INS has particularly broad discretion in the area of drug trafficking, where no conviction is required to deny an immigrant permanent residence. Because of this, immigrants should consult attorneys or advocates who specialize in immigration laws to discuss their situations and any possible options for waivers.

II. HIV AND IMMIGRATION

A. HIV as a Ground for Inadmissibility

HIV has been a ground for inadmissibility since the passage of the Immigration and Nationality Act in 1990. The movement to exclude immigrants who are HIV+ has been motivated by various factors, including a belief that they pose a threat to the health of the citizens and residents of the United States, and that they might well become financial burdens on this country as their health deteriorates.
Inadmissibility on the ground of HIV applies to both non-immigrant (*i.e.*, tourist) and immigrant visas. People entering the country on non-immigrant visas are required to fill out applications that ask if they have ever "been afflicted with a communicable disease of public health significance," which, under immigration law, includes HIV. If a person answers "yes," (s)he will be deemed inadmissible but may solicit a waiver to enter the country for a short period of time as a visitor. If a person who is HIV+ answers "no" and the INS official suspects that (s)he is in fact HIV+ and has, therefore, committed fraud, the INS has the right to deny that person entry into the country.

All non-immigrants soliciting a green card from the United States, whether family- or employment-based, are required to take a medical exam that includes an HIV test. An individual who tests positive may request that this ground of inadmissibility be waived, but (s)he may only do so if (s)he has a U.S. citizen or legal permanent resident parent, spouse or child. This waiver is not available for immigrants who do not have qualifying relatives, nor can it be used by persons attempting to obtain residency via an employer. As a result, some people who test positive for HIV have no way of entering the country legally.

Additionally, in order to obtain the family-based HIV waiver, the qualified immigrant must also state that (s)he (a) understands the modes of transmission of HIV; (b) is receiving treatment and is adhering to doctor's appointments; and (c) is not likely to become a "public charge." For many low-income, HIV+ immigrants who may have received some type of assistance in the past and do not have the resources to

show that they will not need assistance if they become ill, this "public charge" requirement can be the most challenging, as it places them in a difficult situation of having to choose between giving up public assistance or jeopardizing the ability to get a green card on the ground that they will not likely become a "public charge." Unfortunately, there are no guidelines for determining what constitutes a "public charge," and the decision to deny someone a green card on this ground is left to the discretion of the INS officer reviewing the petition.

An immigrant applying for a green card may want to consider undergoing anonymous HIV testing before going for an INS medical examination. This way, (s)he will be able to make informed choices about the immigration process and have time to prepare for an HIV waiver, if one is available.

(1) HIV Immigration and other Immigrants. A person applying for refugee status will also be tested for HIV; however, in this case, a special waiver is available. Additionally, HIV status is not a ground for inadmissibility for asylum applicants; it can, however, form a basis for strengthening the request for asylum. For both refugees and asylees, HIV status will only become an issue when the person attempts to change his or her status to that of a green card holder. A waiver is also available. A person who wins a chance to apply for a green card through the diversity visa lottery will be required to take an HIV test, but no waiver is available in this situation. Finally, those immigrants who obtain residence through a grant of cancellation of removal will not be required to take an HIV test, but, like applicants for asylum, these persons can also use their HIV+ status to strengthen a cancellation request. Contrary to popular belief, HIV status is not an issue for immigrants applying for citizenship.

B. Political Asylum

Some undocumented HIV+ immigrants may have political asylum as an option. As noted earlier, asylum will be granted to an individual if (s)he can show a "well-founded fear of persecution" based on his or her national origin, race, religion, political opinion or membership in a particular social group (*e.g.*, sexual orientation or HIV status). This persecution must be imposed by the government or by a group that the government is unable or unwilling to control. Screening HIV+ immigrants for asylum has become critical since immigration reform. Immigrants have a one-year deadline to file for asylum, from the date of their entry into the U.S., with limited exceptions. Asylum is a complicated process that requires a great deal of preparation and documentation. In general, immigrants with major criminal convictions are statutorily ineligible for asylum.

C. Accessing Public Benefits

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), also known as "welfare reform") limits immigrants' access to many public assistance programs. It also gives states a certain amount of flexibility in designing public assistance programs, including the option to deny benefits to particular groups of immigrants. As a result, the benefits that an HIV+ immigrant can access will vary from state to state.

Whether an HIV+ immigrant can access public benefits will depend on two factors: his or her immigration status and whatever immigrant restrictions exist on the benefit the immigrant is seeking. If a particular benefit has restrictions based on immigration status (*e.g.*, if a benefit requires a verification of immigration status as part of the eligibility process), then everyone who applies for the benefit must provide proof of their immigration status, including citizens.

"Welfare reform" has created sharp distinctions among different categories of legal immigrants. As is discussed below, one result has been to give legal permanent residents who received their green cards before the law was signed on August 22, 1996, more rights than those who received cards after that date.

(1) The five-year bar from receiving "federal means-tested benefits": As of August 22, 1996, legal permanent residents became barred from receiving "federal means-tested benefits" for the first five years from the date of their entry into this country. Stated another way, since August 22, 1996, there has been a five-year bar from the date that the immigrant received his or her green card to the date (s)he could begin receiving "federal means-tested benefits." The term "federal means-tested benefits" is defined by the Department of Health and Human Services to include Supplemental Security Assistance (SSI), Food Stamps, Medicaid and state programs funded under the Transitional Aid to Needy Families federal block grant (TANF), which in New York State is called Family Assistance. Additionally, each legal permanent resident who enters after August 22, 1996, on a family-based visa (or on an employment-based visa where the employer is a family member or where a family member has at least 50% ownership of the employer) is required to have a sponsor. This sponsor, who must be the petitioner, will be required to sign an Affidavit of Support and demonstrate that (s)he is able to support his or her dependents as well as the sponsored immigrant at 125% of the federal poverty level. A petitioner who cannot meet the income guidelines and, therefore, cannot sign the Affidavit of Support, can get a co-signer. The new Affidavit of Support form, which took effect December 19, 1997, is a legally enforceable document, which means that the Government can sue the sponsor for a benefit the immigrant receives if the benefit has an immigrant restriction.

(2) The post five-year bar: Affidavits of Support and Sponsor Deeming. After the five-year bar, the Government will presume that a sponsor's income is available to an immigrant (this is known as "sponsor deeming"), rendering the immigrant ineligible for most programs based on income. Sponsor deeming ends when the immigrant naturalizes (*i.e.*, becomes a citizen), works 40 quarters (the equivalent of contributing enough income into the Social Security Administration for 10 years) or when the sponsor dies. Sponsor deeming can also be deferred to prevent homelessness or hunger of an immigrant with a non-compliant sponsor for a period of up to 12 months.

The implications of the legally enforceable Affidavit of Support are still uncertain, and it raises many currently unanswered questions. For instance: Does a sponsor have the responsibility of paying for all the care and treatment of an immigrant who finds out (s)he is HIV+? Sponsor deeming will not take place until December 19, 2002 -- five years after the new Affidavit of Support became law. Nevertheless, this new requirement may increase the burden on family members petitioning for immigrants who are HIV+.

In New York State, since August 22, 1996, legal permanent residents have had to wait five years before they could access the Family Assistance program. After this five-year bar, New York State will apply sponsor deeming to this program. By contrast, the entirely State-funded Safety Net Assistance program will be accessible to all post-August 22, 1996, legal residents as soon as they can establish State residency of at least one year.

Sponsor deeming will not apply to Medicaid in New York State. Restrictions on immigrants receiving Medicaid will increase the number of uninsured persons who rely on programs not affected by the federal restrictions.

D. Pre-August 22, 1996: Legal Permanent Residents

In general, legal permanent residents who were already residing in this country when welfare reform was signed have more programs accessible to them, including Medicaid, the most important program for HIV+ legal permanent residents in New York State. Before August 22, 1996, there were no immigrant-status restrictions for legal permanent residents who wanted to access Family Assistance in New York State. Legal immigrants who were receiving SSI were grandfathered in as a result of the Balanced Budget Act of 1997, with these benefits undisturbed. By comparison, immigrants who were not receiving SSI on August 22, 1996, but who were already legal permanent residents on that date, will only be able to access SSI if they need to do so as a result of a disability.

Hardest hit by federal welfare reform were the Supplemental Security Income (SSI) and Food Stamp programs, which affected legal immigrant children and the elderly to a great extent. For example, the Food Stamp program is accessible only to those immigrants who were lawfully residing in the U.S. as of August 22, 1996, and who are disabled or who become disabled, were over the age of 65 as of August 22, 1996, and children under the age of 18 who were in the U.S. on that date. The recent Balanced Budget Act and the Agricultural Research Bill have since been signed into law, restoring benefits to a small percentage of those immigrants initially restricted access under the federal welfare legislation.

E. "Forty Qualifying Quarters Exemption"

Legal permanent residents who can demonstrate that they meet the "40 qualifying quarters exemption" will be eligible for both SSI and food stamps. The term, "40 qualifying quarters" was created by the Social Security Administration to mean that, before an applicant could access social security, retirement, disability or survivor's benefits, or Medicare, their "quarters" of income-earning would have to total "40," or, with four quarters to a year, for a period of at least 10 years. For example, in 1996, a person had to earn a minimum of $600 in one quarter of the year in order to be credited with that quarter. If the person earned $2400 in the first three months of employment that year and was unemployed the rest of the year, (s)he would still be credited with four quarters in 1996. If (s)he worked the entire year and made $50,000, (s)he would still only be credited with four quarters.

The "40 qualifying quarters exemption" means that any legal permanent resident who can demonstrate that they have earned "40 qualifying quarters" in combination with a spouse or parent can access SSI or food stamps. To get to the total of 40, a legal permanent resident can use quarters worked by a spouse for the time that was worked during the marriage, including common law marriages and quarters worked by a spouse who has since died. It does not, however, recognize the rights of the divorced; a resident will lose access to his or her spouse's "quarters" once the marriage has ended. Similarly, a legal permanent resident child can borrow "quarters" from both parents for the time they worked while the child was under the age of 18. "Quarters" are not considered lost if they are borrowed; that is, a parent can use the "quarters" being borrowed by his or her child, so that both of them can qualify for the exemption. However, as of December 1, 1996, an immigrant is not permitted to receive "quarters" for any income earned while on public assistance.

Many people either do not understand the "40 qualifying quarters exemption," or they have a difficult time documenting it. Immigrants may work "off the books," where no income is reported, or have worked with other people's social security numbers. Under normal circumstances, a person can find out how many quarters (s)he has been credited with by filling out SSA Form 7004 or Form 7050. Within a few weeks of sending these forms to the Social Security Administration, the person will receive a Personal Benefits

Earnings Statement with all the necessary information. Any errors in the Statement can be corrected with the proper documentation.

F. Veterans' Exemption

Under the SSI and Food Stamp programs, there is also an exemption for veterans and persons on active military duty, which extends to include their spouses, widows and widowers who have not remarried, and unmarried, minor dependent children.

G. Asylees and Refugees

Immigrants who enter the country with refugee status, or who are granted asylum in the United States, can access most programs for the first five years after they are granted their status by the INS, with two exceptions: (1) refugees and asylees can receive SSI and food stamps for seven years from the date they are granted their status; and (2) refugees and asylees receiving SSI-linked Medicaid can receive both for seven years. For all other programs, the five-year time frame applies.

The challenge for social service agencies and service providers is to distinguish between different categories of immigrants to ensure that everyone is correctly linked to programs for which they are eligible. Caseworkers will have an additional administrative burden of status verification, often without having received the training necessary to understand different status levels and without knowledge of changes in the laws as they occur. As a result, many immigrants have been incorrectly denied access to programs.

H. Other Immigrants

There are other groups of immigrants who can receive almost all types of public assistance except SSI and food stamps. These include (1) persons "paroled" -- that is, persons allowed to enter the Country at the discretion of the INS -- for a period of at least one year; (2) persons who are granted withholding of deportation (a status similar to asylum, granted to individuals whose lives or liberty would be threatened if they were forced to return to their country of origin), who may remain for a period of one year or longer; and (3) Cuban and Haitian entrants. In addition, there is a special category of eligibility for immigrants who are granted protection under the Violence Against Women Act (VAWA) as self-petitioners. VAWA immigrants are eligible as long as they can demonstrate that they no longer live with their abuser and that there is a "significant connection between the battery and the need for benefits."

III. UNDOCUMENTED IMMIGRANTS: SERVICES AND BENEFITS AVAILABLE TO ALL REGARDLESS OF IMMIGRATION STATUS

Undocumented immigrants living with HIV/AIDS are likely to be the most marginalized and vulnerable. An HIV+ undocumented immigrant presently has to negotiate his or her health care between the hospital emergency room, via Emergency Medicaid, and services covered under the AIDS Drug Assistance Program (ADAP). Services not covered by either of these programs are usually billed to the patient. In New York State, a hospital will not apply for emergency Medicaid until after a patient has been treated. If a finding is later made that the services offered were not done under emergency circumstances, then the patient will be billed for these services as well. An HIV+ undocumented immigrant who wants to apply for ADAP can do so through a hospital, clinic, social worker or case manager. New York State requires only proof of New York State residency and documentation about income, in order to ensure that the immigrant's income does not exceed the maximum income requirements under ADAP guidelines.

A. The Attorney General's List

Pursuant to federal legislation, the U.S. Attorney General is required to create a list of services which are accessible to all U.S. residents, free of verification or reporting requirements. To date, the Attorney General has not published her list. However, the Justice Department has issued a preliminary guidance, which includes the following programs: school breakfast and lunch programs; testing and treatment of the symptoms of communicable diseases (whether or not the symptoms are caused by the communicable disease); immunizations; prenatal Medicaid (PRECAP); ambulance, fire and police services; domestic violence services; emergency shelters; and food pantries.

The Attorney General has not defined what constitutes programs that are "necessary for the protection of life or safety" of the individual or the community. In the absence of such a delineated list, programs are being instructed to continue "business as usual" until instructed otherwise. Therefore, service providers who have not been told to verify for status should not do so. Similarly, HIV prevention and education programs which have not traditionally asked immigration-status questions are not required to do so. In any case, most of the major programs that are required to verify immigration status have already begun to do so (*e.g.*, food stamps, SSI, etc.).

B. The Fear Factor: Verification and Reporting

Many immigrants do not access services to which they are entitled because they fear being reported to the INS. In fact, welfare and immigration reform have not effectively changed the programs available to undocumented immigrants, yet both have served to magnify the fear factor. While services and benefits that are available to everyone do not have to verify or report immigration status, the law has become so complicated that many immigrants and service providers oversimplify it on the incorrect belief that everyone must be verified and everyone must be reported to the INS. This misunderstanding, coupled with the "public charge" concerns raised earlier, has resulted in increasingly isolating undocumented immigrants from receiving the services they need.

As a matter of law, the reporting requirements are restricted to SSI, food stamps, housing and Family Assistance. Under federal law, agencies which administer these programs are required to report to the INS, four times a year, those persons who are "known to be unlawfully present in the U.S.". This policy requires agency staff to act as enforcement agents for the INS. There is currently no guideline to define the term "known to be unlawfully present." However, the standard clearly requires reporting of "known" and

not of "suspected" persons. Presently, immigrants' rights advocates maintain that the legal point at which someone can be considered "known" to be unlawfully present is when the INS -- the only federal agency authorized to make determinations about immigration status -- has decided and issued a final order of removal (deportation) against the immigrant. Furthermore, there is currently no information-sharing that would allow a social service agency to find out if an immigrant has an order of removal on his or her record, and immigrants' rights advocates contend that this information should remain confidential, since it is only the INS that should be responsible for immigration law enforcement.

In applying for the Family Assistance Program in New York State, an applicant is required to assert whether he/she and household members are qualified aliens. If alien status is indicated, verification of this status may be sought. Some eligible applicants may fear that applying for public assistance will bring to light the presence of an undocumented family member.

C. New York City and Information-Sharing with the INS

In 1989, New York City passed Executive Order 124, prohibiting communication between its officials and the INS unless criminal activity was suspected. Founded on the principle that the safety of all City residents applies to *all* residents, irrespective of their immigration status, the fundamental intent of the Order was to encourage undocumented immigrants who witnessed or were victims of crimes to report this information to the proper authorities and to encourage them to seek necessary health care services, especially in cases of communicable diseases.

However, both welfare and immigration reform legislation contained provisions to overturn the Order, by mandating that no state, city or local government could prohibit communication between its officials and the INS. It is important to note that the Order did not require reporting at all levels, but it simply opened the door for links between service providers and the INS. New York City challenged this provision on constitutional grounds and lost and, while NYC has stated its intention to appeal this decision, undocumented immigrants currently can not be assured that any information they share about the legality of their status will remain confidential.

D. Verification and Emergency Medicaid: a Special Case

Under federal legislation, the U.S. Attorney General is also required to issue guidelines on how states and localities should verify immigrants' status. Federal reimbursement is contingent on this verification. While there are no reporting requirements under Emergency Medicaid, since it is a service that is available to everyone, it is possible that verification will be required in emergency rooms. If this occurs it will create Emergency Medicaid verification and could deter undocumented immigrants from a program that they have traditionally been able to rely upon.

E. Immigrants with AIDS Permanently Residing Under Color of Law in New York City (PRUCOL)

There are two categories of undocumented immigrants with AIDS in New York City: those who are considered to be permanently residing under color of law (PRUCOL) and those who are not. Immigrants who are PRUCOL currently have access to more assistance than those who are not.

PRUCOL is not an immigration status, but, rather, was used as a public benefits eligibility determinant prior to welfare reform. An immigrant is considered to be permanently residing under color of law, and not likely to be deported, if (s)he is known to the INS. Many immigrants can be considered PRUCOL,

including asylum applicants and adjustment applicants (that is, immigrants waiting to change to another, more permanent immigration status).

F. Extended Voluntary Departure (EVD)

Before immigration reform, many undocumented immigrants with AIDS could be granted Extended Voluntary Departure (EVD) by New York City INS districts, which would enable them to receive public assistance. This came about, in part, as a result of advocates' ability to successfully argue that immigrants who were granted EVD should be able to receive benefits whenever necessary, since they were known to the INS and were not likely to be deported. Under EVD, an immigrant usually received a one-year grant, was eligible for employment authorization, and could not be deported before the date indicated on the voluntary departure form. When the expiration date occurred, immigrants could simply renew their EVD for another period. Each public benefit made its own determinations about who was PRUCOL for the purposes of eligibility; SSI and Medicaid had the most liberal definitions. State welfare PRUCOL determinations varied from state to state. Extended Voluntary Departure is no longer possible as a result of immigration reform, and PRUCOL is no longer a basis for public benefits eligibility under federal law.

G. Benefits for AIDS PRUCOLs

AIDS PRUCOLs can access both Emergency Medicaid and ADAP, as well as receive benefits under Home Relief, which is now called Safety Net Assistance in New York State. Under federal law, they can no longer receive SSI after September 30, 1998. In addition, under State law, PRUCOLs can also access Medicaid if they were PRUCOL based on an AIDS diagnosis as of August 4, 1997. All PRUCOLs can access the State Safety Net Program irrespective of either the date they became PRUCOL or the date they applied for benefits, and PRUCOLs who were receiving SSI prior to September 30, 1998, will have to transition to the Safety Net Program, which will result in a significant reduction in cash assistance.

In the absence of EVD, undocumented immigrants who cannot change their status under immigration law and who are not PRUCOL can no longer affirmatively apply to become PRUCOL. Currently, legal advocates are exploring the possibility of Deferred Action, the last immigration remedy left to the discretion of the INS. Deferred Action is similar to extended voluntary departure insofar as it facilitates employment authorization, and an immigrant cannot be deported during the period of the grant. Under the current law, an immigrant soliciting Deferred Action can establish PRUCOL eligibility for Safety Net Assistance; (s)he will not be eligible for Medicaid because of an August 4, 1997 cut-off date in New York State, and can only rely on Emergency Medicaid and ADAP. It is still unclear, however, whether immigrants who apply for Deferred Action will be putting themselves at risk of being deported if their request is denied. As a result, legal advocates are proceeding cautiously, particularly since deferred action is rarely granted by the INS.

IV. IMMIGRANTS WITH CRIMINAL CONVICTIONS

HIV + immigrants who have criminal convictions are also affected by changes in immigration law. Depending on the seriousness of the conviction, an immigrant can be denied entry into the country or change of immigration status, or be deported. Immigrants have always been deportable for certain criminal convictions. However, the definition of what constitutes deportable crimes has been expanded under the new laws, and waivers previously available to "forgive" a deportable offense have been virtually eliminated. In many cases, the INS is now mandated by law to deport an immigrant without any exercise of humanitarian discretion, irrespective of the amount of time the immigrant served or the date of the conviction. As a result, over 60% of the immigrants who have been deported from New York City were removed as a result of criminal convictions.

A. Deportable Offenses

Although there is no clearly defined list of deportable offenses, the types of crimes which can result in deportation are divided into two categories: aggravated and non-aggravated felonies. The definition of an aggravated felony under immigration law is much broader than that of aggravated felony under criminal law. In general, the INS will consider the crime and the sentence that could have been imposed at the time the immigrant was convicted. For example, an immigrant who pleads guilty to a first offense of drug possession and receives a sentence of probation will still be mandated deportable under immigration law, without having any immigration relief available. In the past, an immigrant in this situation had options for waiving this ground of deportation. Accordingly, if an immigrant's sentence could have been a year or more, the service provider is advised to refer the immigrant to legal counsel and not to send them to naturalize or submit other petitions to the INS if possible, nor to travel abroad.

By comparison, non-aggravated felonies have a Cancellation of Removal option for immigrants who have the required number of years of physical presence in this country (that is, seven years for legal permanent residents and 10 years for all others) and who can show hardship to a legal permanent resident parent, spouse or child. Two minor crimes can sometimes amount to an aggravated felony under immigration law. This convergence of criminal and immigration law is extremely complex and presents a challenge to providers who assist HIV+ immigrants with criminal convictions. During the first few months after immigration reform, many criminal attorneys were unaware of the immigration consequences of criminal convictions and often encouraged immigrant clients to plea bargain. As a result, many of these immigrants unknowingly pled to deportable offenses.

Providers should be sensitized to the fact that changes in public benefits eligibility for non-citizens has created a strong push towards naturalization, and that, for many immigrants in this situation who are unknown to the INS, submitting a naturalization application could result in facilitating the deportation process. Providers should also be aware that, in many prisons, the INS continues to detain deportable immigrants upon completion of their sentences, which raises concerns about the continuity of care and access to medications.

Substance abusers who have not been incarcerated or convicted should also be made aware of the consequences they might confront, as the threat of deportation will result in a drastic change in quality of life and separation from a whole series of medical and other support networks, including friends and families.

Because of the importance of the many welfare- and immigration-related changes in the laws and policies discussed in this report, and the effect they will have on the lives of many HIV+ immigrants, there are a few key issues that should be given more attention:

(1) The US's new immigration laws will continue to keep HIV+ immigrants in a legal limbo where they will be unable to change their immigration status. Since the HIV waiver is not available to everyone, many immigrants who might otherwise have a way to resolve their undocumented status will be unable to do so and will remain vulnerable to deportation. Moreover, without a legal status that facilitates employment authorization, many HIV+ immigrants will face exploitative working conditions and will be kept from any gainful employment that might facilitate health care coverage.

(2) Medicaid reforms in New York State allowed coverage to continue for immigrants with an AIDS diagnosis who were designated as PRUCOLs and were receiving Medicaid on or before August 4, 1997. PRUCOLs with an AIDS diagnosis after that date may receive Medicaid coverage only for treatment of emergency medical conditions, if otherwise eligible.

(3) The changes in welfare and immigration law require more community education programs sensitive to the needs of HIV+ immigrants. Many HIV/AIDS service providers do not know enough about the intersection of HIV and immigration. This lack of information hinders service delivery and impedes community education in those areas where services are being offered. Community education is needed not only to encourage testing and to inform the community about legal options but also to underscore that, while not all supportive services are available, many immigrants' prevention and treatment needs can be addressed without regard to immigration status. Knowing one's HIV status is always better than not knowing.

(4) There is a lack of comprehensive HIV-related legal services for immigrants outside Manhattan, where most HIV+ New York City residents receive services. This is especially problematic in rural areas where there are immigrants and migrants living with HIV and AIDS. Furthermore, HIV-related legal services which are targeted to immigrants should be sensitive to such issues as welfare reform, domestic violence and immigrants with criminal convictions. These services should be located in immigrant neighborhoods and in other areas that have earned the trust of immigrants, and they should also offer training for staff members of community-based organizations and hospitals serving HIV+ immigrants, to assist them in becoming sensitive to the specific needs of this group.

APPENDIX A

Cultural Overview for Haitian Community

Summarized from Report prepared by Haitian Women for Haitian Refugees

Immigration Patterns and Statistics. While Haitian migration to the United States has been taking place since the beginning of the century, the first large wave occurred in the 1960's, during the reign of Francois "Papa Doc" Duvalier. Thousands of Haitians went into exile in South America, the United States and West Africa. The second wave of immigration started in the 1970's, when Jean Claude "Baby Doc" Duvalier succeeded his father. Immigration continued in large numbers through 1986, even after Duvalier was overthrown, leaving Haiti in economic and political disarray.

Guantanamo HIV+ Refugee Camp. In 1993, 268 HIV+ Haitian refugees and their families were determined to have "well-founded" fears of persecution and thus qualified for entry into the United States as political refugees under U.S. law. Because of their HIV+ status, however, they were imprisoned on the American military base at Guantanamo, Cuba. A federal district court judge, who termed the prison conditions "unconscionable", later ordered the Haitians released from their imprisonment.

Guantanamo Refugees. Upon their entrance to the United States, the refugees found that their problems were just beginning. Aside from the language difficulties, there were few agencies -- including Haitian agencies -- able to handle the needs of the new population. Many of the refugees were ostracized from their families because of their HIV status, and many were in denial of their status, considering the determination of the U.S. Government an "accusation" that they had HIV/AIDS. Some immigrants faced deep bouts of depression and a serious lack of basic social services and housing. Even many members of the Haitian community shunned the "refugees with SIDA," treating them as "lepers".

Language. French has always been thought of as the language of social status and refinement. It is no surprise, then, that Haitian Kreyol was considered by many of the elite as an inferior tongue. Many children learned French in school but continued to converse with their parents in Kreyol at home. The stigma was officially ended when, in 1987, the new Haitian constitution under President Aristide was written in Kreyol, which was declared the official language of Haiti.

Prevention. The best mediums for communicating prevention messages to the Haitian community may be cassette and video, as there is very high illiteracy rate among recent Haitian immigrants and printed matter is unlikely to be successful in reaching those most at risk.

"**Refugee".** How one immigrated to the United States is important to some members of the Haitian community. Those arriving within the last few years in sheer desperation in homemade boats "are considered depraved and/or refugee." The term "refugee" connotes helplessness and desperation and carries stigma.

Age. The older members of the Haitian community carry traditional beliefs toward HIV. Some believe that HIV is a hex that can be treated with herbal medicine. They are, for the most part, in denial that such a terrible disease exists. Even the Guantanamo population remained in denial until they began to see their compatriots die of AIDS.

Gender. Haitian women tend to be submissive and controlled by their husbands, because Haiti is a patriarchal society. The repression of women invariably finds its way into the bedroom. Women feel

obligated to have sex with their husbands according to the man's desires. Haitian women have come to accept that men keep mistresses; the practice is seen as part of the male nature. Female promiscuity is synonymous with lacking Christian values.

Prevention Recommendations. It cannot be emphasized enough that HIV/AIDS is taboo in the Haitian community, and that it is not easily discussed. In terms of prevention that works, the disease must be brought to life and it must be made clear that it is not a conspiracy by the medical establishment.

- Bring the disease to life by disseminating clear factual messages regarding HIV risk and illustrating how it deteriorates the body in both males and females over time.
- Women have to be empowered and taught to take responsibility for their own well-being. This means consistent condom use should be stressed.
- Good prevention means establishing some kind of "comfortable meeting place" to educate the Haitian community about homosexuality. Many Haitian men who have sex with men are also married.
- Break stereotypes and show that regardless of class, anyone can contract HIV.
- Emphasize that religion does not exclude one from getting HIV. Some followers of Christianity believe that HIV infection is a matter of fate, and they distrust prevention. Some followers of Voodoo use remedies such washing the penis with lemon to kill the germ.

Who Should Deliver Prevention Messages. It was suggested that well-trained and trusted individuals who are aware and have experience working effectively with this population should "administer this difficult task." Most appropriate would be medical personnel who have a commitment, sensitivity and excellent track records in dealing with this population. However, these people should be based in a community center environment, as medical facilities tend to have an air of "doom" that can be counterproductive.

Cultural Overview for Chinese Communities

Summarized from Report prepared by Asian and Pacific Islander Coalition on HIV/AIDS

Immigration Patterns and Statistics. According to the 1990 Census, New York City's Asian and Pacific Islander (API) population of 512,719 is 47% Chinese, 18% Indian, 13% Korean, 8% Filipino, 3% Japanese and 3% Pakistani. An additional 12% include Vietnamese, Bangladeshi, Thai, Cambodian, Indonesian, Guamanian and others. Presently comprising 7% of the total NYC population, this population has grown by 12% since 1980, the highest increase of all racial groups. Recent immigrants, migrants and refugees, who generally have the most difficulty accessing mainstream services because of language and cultural barriers, make up 77% of the City's expanding API population.

Lesbian, Gay and Bisexual Asians. An estimated 50-75,000 Asian and Pacific Islanders living in New York City identify themselves as lesbians, gays or bisexuals. Forty-one percent are considered "linguistically isolated." Fifteen percent live below the poverty level. The fastest growing rate of hate-motivated crimes is violence against Asian and Pacific Islanders.

"Model" Minority. The API population is too often misrepresented as a "model" minority that does not experience social problems. This misperception is partly a result of a "dual migration stream," which includes a high proportion of highly-skilled and low-skilled immigrants. This dual migration is clearly seen among Chinese immigrants, more than 30% of whom are in the professional category (compared to less than 17 % of the total population) and 30 % of whom are manual laborers and service workers.

Numbers in New York. Unlike Asian and Pacific Islander communities in San Francisco and Honolulu, where they comprise 30% or more of the population, APIs make up a small percentage of the total population of NYC. This fact, combined with the "model" minority myth, tends to marginalize this community and make it invisible.

HIV/AIDS. Some estimates indicate that HIV seroprevalence may be as high as 36.5% among substance users and men who have sex with men in major cities of mainland China. Asian and Pacific Islanders represent 405 of the cumulative total of 19,782 cases of foreign born person with AIDS in New York State through December 1997. HIV seroprevalence among Asian women giving birth in NYS from November 1987 through December of 1996 was .07%.

Health Care. Compared to other groups, Asian and Pacific Islanders show a disproportionate, higher rate of tuberculosis (TB) and hepatitis B, two co-morbidity factors of HIV. In 1994-95, there was a decrease of TB across all racial groups except APIs.

Barriers to Health Care. While Asian and Pacific Islanders represent an expanding population with increasing needs for HIV-related services, they are prevented from adequately accessing services due to the following barriers: lack of culturally competent, linguistically accessible and HIV-sensitive providers; lack of health insurance; distrust of institutions; stigma around sex, substance use, homosexuality, illness and death; and lack of coordinated primary care and case management services.

Cultural taboos have also created barriers to health care. Discussions of sex and substance use are discouraged in most API cultures. Homosexuality is considered shameful and a threat to the continuation of "traditional" family lines, particularly in Christian communities, many of whom believe that same sex relationships are a Western phenomenon that does not exist in their communities. Issues related to dying are rarely discussed because of a belief that such discussions will result in added psychological distress.

Cultural Overview for the Dominican Community
Summarized from Report prepared by Julio Dicent and Nineta Regalado

Immigration Patterns and Statistics. The Dominican population in New York City rose from 332,713 in 1990 to 495,000 in 1997, making it the second largest Hispanic group in the City, after Puerto Ricans. The highest concentration of Dominican-born immigrants occurred in three waves: in the late 1960's, at the beginning of the 1980's and in the 1990's. Although Dominicans were first concentrated in the areas of Delancey Street and the Upper West Side, by the 1990's, Washington Heights housed the highest *per capita* concentration of Dominicans in the City. Close to sixty (60%) percent of all Dominicans in the United States resided in NYC in 1997. As a result of gentrification and low vacancy rates in Washington Heights, the Dominican population is presently growing faster in the Bronx, Queens and Yonkers. However, a growing share of the Dominican population is choosing to live outside New York.

Socioeconomic Factors. Key socioeconomic indicators have deteriorated sharply over the 1990's for the Dominican population in NYC. Unemployment increased, poverty rates rose, earnings stagnated; the relatively unskilled population fared worse in 1996 than it did in the late 1980's.

A major reason for the economic difficulties suffered by the Dominican population in NYC is related to their slow educational attainment. In 1997, approximately 54.7% of Dominicans who were 25 years of age or older had not completed high school or its equivalent. Only 4% had completed college in 1997, compared to 26.8% for New Yorkers overall.

HIV/AIDS Among Dominicans. Existing epidemiological data on Dominicans with AIDS in NYC is, although small, sufficiently diverse by age and geographic location to be an important indicator of the risk behaviors and patterns of infection among Dominicans in the City. Manhattan has the highest rate of Dominicans with AIDS, followed by the Bronx. The highest risk behavior is MSM and injection drug use (IDU). For women, heterosexual contact remains the primary risk factor.

Projections of the AIDS epidemic in the Dominican Republic indicate that by the year 2000, HIV prevalence will reach 5 % of the adult population, or, that over 300,000 people will be HIV+. As a direct result of AIDS cases and death rates (17,600 per year), it is estimated that 55,000 children will be orphaned. This is an indicator of the potential impact on the Dominican community in NYC in light of the high rates of cross- migration from the Dominican Republic to the United States.

Health Care. Compared to other groups, Dominicans show a lack of consistent use of health care services due to the lack of health insurance. Most Dominicans are employed in factories, in "bodegas", or as domestic workers, types of employment that, most often, do not provide health insurance.

Due to the cross-migration from NYC to the Dominican Republic, and vice-versa, Dominicans find their emotional and personal ties in the Dominican Republic. Many go back to their home country ("home") to receive medical care. In NYC, Dominicans access medical care on an emergency basis or at community-based clinics that are Spanish-speaking and have staffs of Dominican descent.

Barriers To Health Care. Dominicans represent a growing population in need of HIV-related services and health care who are prevented from accessing these services due to the following reasons: lack of culturally- competent and linguistically-accessible services; lack of health insurance; distrust of

government institutions; stigma around HIV, sex and homosexuality, and immigration status. Many social service organizations lack an understanding of migration patterns and the cultural transitions that Dominicans experience as they come to this country. This has an impact on how services are delivered to a community much in need.

APPENDIX B

AIDS IN FOREIGN COUNTRIES

Familiarity with the numbers of reported AIDS cases in other countries is important in determining prevention programs in the United States, as it enables prevention educators to be familiar with the experience of HIV/AIDS of the immigrant communities. For example, a prevention message to immigrants from Country A, where AIDS is associated with prostitution, would be very different from a prevention message for immigrants from Country B, where AIDS is associated with injection drug use. The following statistics may be helpful in program design even though the data do not offer the depth of detailed cultural information a provider may need. Such in-depth information can only be gathered by research and from interviews with residents of a particular country.

				Seroprevalence Estimate**			
				Capital/Major City Risk		Rural Risk	
	1993	1994	1995	Low	High	Low	High
All Countries ***	151209	144354	128033				
Africa			6114				
Asia			35429				
Europe			31159				
North America			41168				
Oceania			204				
South America			13659				
Individual Countries ***							
Afghanistan			314				
Albania			350				
Algeria			131		0.0		
Antigua-							
Barbuda			33				
Argentina			207	0.1	6.3	0.2	2.0
Armenia			508				
Aruba			8		0.0		
Australia			160				
Austria			72				

				Seroprevalence Estimate**			
				Capital/Major City Risk		Rural Risk	
	1993	1994	1995	Low	High	Low	High
Azerbaijan			604				
Aruba			8				
Bahamas			46	3.6	18.4		
Bahrain			16		0.0		
Bangladesh			3397	0.0			
Barbados			377	1.2			
Belarus			1562				
Belgium			71				
Belize			137				
Benin			6	1.4	50.8	4.9	
Bermuda			16				
Bhutan			1				
Bolivia			92				
Bosnia-Herzegovina			156				
Botswana			2	22.5	31.9	7.5	
Brazil			470	0.5	24.0	0.3	0.0
British Virgin Islands			21	2.8			
Brunei			2				
Bulgaria			300				
Burkina Faso			3	11.0	60.4		
Burma			208	1.3	18.0		
Burundi			1	20.0		1.8	
Cambodia			31	4.3	38.0		
Cameroon			42	5.7	45.3	2.9	9.0
Canada	1391	1277	110				
Cape Verde			3				
Cayman Islands			2	0.0			
Central African Republic			0	16.0	31.0	6.5	
Chad			2	4.1			
Chile			203	0.1	1.3		

				Seroprevalence Estimate**			
				Capital/Major City Risk		Rural Risk	
	1993	1994	1995	Low	High	Low	High
China (Mainland)	13958	11745	11252	0.0	36.5		
Christmas Island			0				
Cocos Islands			0				
Columbia	3674	2888	2573	0.0	1.1		
Comoros			0				
Congo			3	7.1	17.6	2.6	
Cook Islands			0	0.0			
Costa Rica			128	1.1	4.3		
Croatia			11				
Cuba	315	247	231	0.0	0.0		
Cyprus			43				
[Former]							
Czechoslovakia			283				
Czech Republic			7				
Denmark			50				
Djibouti			1		43.0		
Dominica			337				
Dominican Republic	26799	28250	21412	1.7	4.9		
Ecuador	3988		3147	0.0	3.6		
Egypt			1265	0.0	5.3		
El Salvador	2711	1983	988	0.7	2.2		
Equatorial Guinea			68				
Eritrea			37	1.6			
Estonia			28				
Ethiopia			261	6.2	54.2	8.6	65.6
France			308				
French Guinea			2				
French Polynesia			1	0.0	3.0		
French Southern and							
Antarctic Lands			0				
Gabon			4	1.6			
Gambia			53	0.1	13.6		
Gaza Strip				0.0			
Georgia			237				

				Seroprevalence Estimate**			
				Capital/Major City Risk		Rural Risk	
	1993	1994	1995	Low	High	Low	High
Germany	521	481	501				
Ghana			1054	4.2	37.5	1.6	
Gibraltar			2				
Greece			247				
Greenland			0				
Grenada			384	0.0	2.4		
Guadeloupe			14				
Guam			0	0.1			
Guatemala	1089	708	538	0.0	8.5		
Guinea			68	0.7	36.6	0.3	
Guinea-Bissau			0	1.8		0.5	
Guyana	6082	5320	5127	6.9	25.0		
Haiti	3643	4527	3482	15.7	70.0	4.0	
Honduras			1063	2.5	15.0		
Hong Kong	1625	1318	1240	0.0	0.1		
Hungary			104				
Iceland			12				
India	5338	5338	4836	1.1	29.1		
Indonesia			74	0.0	0.3		
Iran	799	563	434				
Iraq			162				
Ireland	4411	5142	1528				
Israel			572	0.0	1.1		
Italy			448				
Ivory Coast			108	11.8	77.0	3.3	
Jamaica	7992	6366	6856	0.4	9.3		
Kenya			67	17.1	85.5	6.3	
Kiribati			1	0.1			
[North] Korea				0.0			
[South] Korea	2022	1904	1752	0.8	0.0		
Kuwait			65				
Kyrgyzstan			58				
Laos			25	0.8	1.2		
Latvia			217				
Lebanon			275				

				Seroprevalence Estimate**			
				Capital/Major City Risk		Rural Risk	
	1993	1994	1995	Low	High	Low	High
Lesotho			0	6.1	11.1	4.2	21.3
Liberia			263				
Libya			20				
Liechtenstein			0				
Lithuania			143				
Luxembourg			0				
Macau			62	0.0			
Macedonia			20				
Madagascar			11	0.0	0.3	0.0	0.4
Malawi			3	30.2	70.0	10.7	
Malaysia			172	0.0	29.5		
Maldives			0	0.0			
Mali			47	4.4	55.5	3.4	52.8
Malta			39				
[Northern]							
Latvia			217				
Lebanon			275				
Marianas Islands			0				
Marshall Islands			0	0.0			
Martinique			2				
Mauritania			5	0.4			
Mauritius			12		0.8		
Mauru			0				
Mexico	1911	1310	111	0.6	5.0		
Micronesia			0	0.0			
Moldova			913				
Mongolia			2	0.0	0.0		
Monaco			1				
Namibia			0	4.7	7.2		
Nepal			20	0.2	0.8		
Netherlands			104				
Netherlands							
Antilles			7				
New Caledonia			0	0.1			
New Zealand			32				

				Seroprevalence Estimate**			
				Capital/Major City Risk		Rural Risk	
	1993	1994	1995	Low	High	Low	High
Nicaragua			197	0.0	1.6		
Niger			3	1.3	12.6	1.4	
Nigeria			1229	6.7	29.1		
Niue			0				
Norway			18				
Oman			2				
Pakistan	2056	2200	2677	0.0			
Palau			0	0.0	0.0		
Paraguay			137	0.0			
Panama			399				
Papua New							
Guinea			1	0.0	0.3	0.0	0.0
Peru	2062	1770	1266				
Philippines	4905	3878	3214	0.0	0.5		
Pitcairn Islands			0				
Poland	6517	6773	3051				
Portugal			264				
Puerto Rico			1				
Qatar			2				
Reunion			0				
Romania			769				
Russia			4014				
Rwanda			0	25.4	73.2		
St. Helena			0				
St. Kitts and Nevis			37	2.0			
St. Lucia			144	0.0			
St. Pierre and							
Miquelon			0				
St. Vincent and							
Grenadines			215	0.2	1.4		
[American]							
Samoa			0				
San Marino			0				
Sao Tome and							
Principe			1				

				Seroprevalence Estimate**			
				Capital/Major City Risk		Rural Risk	
	1993	1994	1995	Low	High	Low	High
Saudi Arabia			86	0.0			
Senegal			253	1.7	10.1	0.6	9.2
Seychelles			1				
Sierra Leone			96		26.7		
Singapore			32	0.0	3.7		
Slovakia							
Solvenia			17				
Solomon Islands			0	0.0	0.0		
Somalia			106		2.4		
South Africa			119	5.8	20.1	6.4	
[Former]							
Soviet Union	14345	19618	20300				
Spain			512				
Sri Lanka			142	0.0	0.1		
Sudan			197		16.0		
Surinam			80	0.8	2.6		
Swaziland			1	21.9	11.1		
Sweden			96				
Switzerland			100				
Syria			337		0.0		
Taiwan	1135	851	702	0.0	0.4		
Tajikistan			674				
Tanzania			69	16.1	49.5	15.0	34.3
Thailand			137	2.8	21.6		
Tobago		3496	2577	0.3	14.7		
Tunisia			27	0.0			
Turkey			770	0.0	1.6		
Turkmenistan			38				
Turks and Caicos							
Islands			4				
Tuvalu			0	0.0			
Uganda			21	18.5	38.5	6.5	
Ukraine			6128				

				Seroprevalence Estimate**			
				Capital/Major City Risk		Rural Risk	
	1993	1994	1995	Low	High	Low	High
United Arab							
Emirates			48				
United Kingdom	2059	1894	1620				
United States			11				
Uruguay			56	0.2	21.5		
Uzbekistan							
Vanuatu			0				
Venezuela			299	0.1	6.1		
Vietnam	1759	995	963	0.0	31.9		
[US] Virgin Islands			0				
Wallis and							
Futuna Islands			0				
West Bank				0.0			
Western Sahara			0				
Western Samoa				0.0			
Yemen			629				
[Former] Yugoslavia			1144				
Yugoslavia			340				
Zaire			42	5.0	34.8	2.9	25.4
Zambia			18	27.9	58.0	12.7	36.0
Zimbabwe			13	32.0	86.0	16.0	46.0

* Immigration and Naturalization Service, Statistics Division, Operational Statistics Branch, Washington, DC.
** Health Studies Branch, International Programs Center, Population Division, US Bureau of the Census, 1996.
*** Continental totals reflect immigration only. Individual country counts include immigration and legalized aliens.

APPENDIX C

FOCUS GROUP PROTOCOLS

Prepared for the Latino Commission on AIDS
by Latino Commission on AIDS and Partnership for Community Health
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QUESTIONS	CONCEPT
1. Introduce yourself and tell the others in the group a little about yourself. Only use your first name.	Warm up Self-concept.
2. How long ago did you come to US and New York and why did you come? PROBE: Plan to return?	How settled they are. Access to information and/or health services.
3. Do you have any family members living with you? PROBE: wife/husband and/or children?	Social Networks. Need for services in the family.
3.1. Do you plan to have (more) children? How important having children to you?	Birth control vs. HIV protection.
4. Do your children go to school? Do you talk to the teachers? Do you work with your kids doing homework?	Explore possible school connection for HIV/AIDS information
5. Who do you normally spend time with? Who do you socialize with? What do they have in common with you? PROBE: work, neighborhood, ethnicity/national origin.	Social networks.
5.1. Do you usually spend time with your co-workers outside work? About how often? What do you do when you get together with them?	To determine sense (if any) of community with co-workers. Concept of community. The place of housing works
6. Do you usually spend time with people from _____ (nation of origin)? About how often? What do you like do when you get together with them?	Social meaning of ethnic affiliation
7. How often do you go to meeting to discuss work conditions or health conditions? Would you go if you were invited? With who? Who invites you or organizes these meetings?	Community organization
8. What are your favorite places to go outside of work?	Places of congregation
9. Here is a list of things that some people do. How many of your friends do any of these activities? (SHOW LIST) How important are they to you? Why do people do them?	Risk behaviors for HIV/AIDS, importance of behaviors in life, need for love, intimacy, fun, escape, etc.
10. When people engage in these types of things, how much power (control / ability) do they have to reduce or stop how much they do?	locus of control
11. In general, do you feel you pretty much are in control of your life, or do you feel like you are always doing something someone else wants you to do?	self efficacy
Let's talk a little about your health	
12. What are the most important health problems that your friends or community are facing now?	Perception of HIV/AIDS as a problem in their communities.
13. What are the most important health problems that you and your family are facing now?	Perception of HIV/AIDS as a personal problem
14. What are your most important concerns regarding your health and the health of your family? PROBE FOR STDs, HIV/AIDS FOR CHILDREN'S HEALTH NEEDS.	Health care needs. Perception of HIV/AIDS as part of family's health needs.
15. Who do you go to if you have a health problem?	Information seeking
16. Where do you usually get information about health issues? (PROBE FOR: friends, family, community members, health services, media).	Formal and informal sources of health information.
Now I would like to ask you some questions about AIDS	
17. When I say AIDS, what comes to your mind? (PROBE FOR CONSPIRACY BELIEFS – US GOVT IS INFECTING GROUP ETC.)	Basic recognition of HIV/AIDS. Attitudes towards HIV infection.
18. When I say HIV infection, what comes to your mind? Can a person look healthy and be infected? How long after becoming infected does a person become sick?	knowledge about HIV
19. Do you personally know anyone who is HIV positive or has	Social Network. - proximity to AIDS

AIDS? You don't have to mention names.	
20. In your [community] [camp] how many men and women do you think are infected with HIV? READ LIST Almost all? Quite a few? Not too many? Almost none? (Raise Hands)	Perception of overall risk, fatalism
21. Why do you think they got infected?	Knowledge about risk behaviors. Attitudes towards people living with HIV/AIDS. Misperceptions
Now going back to the list we talked about before – the kinds of thing people do to have fun....	
22. How are these activities related to getting infected with HIV?	Knowledge about risky behaviors.
23. Before you or your friends do in any of these behaviors, do you think of the possibility of getting infected? Why? Why not?	Perception of risk., factors associated with risk behaviors, anxiety
24. Some of these things can spread the HIV virus. Do you know how sexual intercourse can be less risky for spreading AIDS? Do you use condoms? Why? Why not? (PROBE FOR AVAILABILITY, COST, TRUST OF PARTNER, ATTITUDE TOWARD CONDOMS, ETC.)	Barriers and other factors associated with risk behaviors. Attitudes toward condoms
25. When you think about having sex, do you think that penetrative sex - fucking - is the only thing to do? What are some other things people might like to do? Do you like those other things?	Attitudes toward safer and unsafe sex
26. How do you think having a sexually transmitted disease is related to HIV infection and AIDS? (PROMPT FOR TRANSMISSION AND PROGRESSION)	Knowledge of relationship between STDs and AIDS
27. Have your friends ever shared needles? Do you know that sharing needles can spread AIDS? How is it possible to reduce the chance of HIV infection from sharing needles?	Barriers and other factors associated with risk behaviors.
28. Do you think you, personally, are at risk of getting AIDS?	Personal risk
29. Is there anything about being a (man) (women) that places you at special risk (PROBE: EXPLORE SEX ROLES	Sex roles
30. NOW I WOULD LIKE TO TALK ABOUT WHO YOU TRUST TO GIVE YOU ADVICE HEALTH ISSUES	
31. Where do you usually get information about HIV/AIDS? (PROBE FOR NEWSPAPERS/MAGAZINES, TV, RADIO, TALKS/WORKSHOPS, FRIENDS, DOCTORS, CLINICS, COMMUNITY BASED ORGANIZATIONS, SPIRITUAL LEADERS)	Formal sources of information.
32. Think of the last time you obtained information about HIV/AIDS from these sources. Was the information presented in your native language?	Changes in attitudes, language.
33. Do you think the information was presented in a language that was easy for you or a member of your community to understand?	Educational level.
34. Was there anything in the way the information was presented that wasn't appropriate for people from your ethnic background or community?	Cultural sensitivity
35. What have you learned about HIV/AIDS from these sources?	Content.
36. Who would you trust the most to give you advice about preventing HIV infection? Who do you think other [men] [women] in your neighborhood trust? (PROBE: media, book, friends, co-worker, doctor, community based organization? etc.)	Credibility of sources of information for prevention.
37. Did the information make you think or feel differently about HIV-preventive behaviors? In which ways? (PROBE FOR increased perception of risk, attitudes towards behaviors, feelings of self-efficacy, beliefs of control over one's health)	Impact of the information.
38. What additional information about HIV/AIDS would you like to get?	Information needs.
39. IF YES, What prevents you from getting this information? (PROBE FOR transportation, time, language)	Barriers to accessing information.
40. If there was some kind of get together to talk about HIV and	Interest and barriers

AIDS would you come? Why or why not (PROBE: transportation, lack of interest, etc)	
NOW I WOULD LIKE TO TALK ABOUT HIV TESTING	
41. In your (neighborhood/community/camp) How many people do you know who have been tested for HIV infection?	Testing Norms. Information about testing sites.
42. If you decided to get tested, where would you go? Why?	Access to HIV testing sites
43. If you find out that you are HIV positive, what would you do? Where would you go for help?	Attitudes towards HIV/AIDS. Post-test counseling needs.

THINGS SOME PEOPLE DO:

Meeting with friends and getting a buzz on some alcoholic drinks

Getting high on a few drinks when you are alone

Getting high on drugs with a group of friends

Getting high on drugs when you are alone

Having sex with your regular partner

Playing the field and having sex with several others

APPENDIX D

List of Laws Affecting HIV+ Immigrants

- Immigration and Nationality Act of 1990
- Violence Against Women Act of 1994
- Personal Responsibility and Work Opportunity Reconciliation Act of 1996
- Illegal Immigration Reform and Immigrant Responsibility Act of 1996
- Balanced Budget Act of 1997
- Welfare Reform Act (New York State)
- Agricultural Research Act of 1998
- Non-citizen Benefit Clarification and other Technical Amendments of 1998

APPENDIX E

Quick Reference Glossary of Important Immigration Terms

Citizen (USC): person born in the United States, a U.S. territory or abroad to citizen parents

Naturalized Citizen (USC): person born outside the U.S. who applies for citizenship by fulfilling certain requirements. The person applying for citizenship must show that (s)he is at least 18 years of age, has been a legal permanent resident and resided in the U.S. continuously for the last five years, has good moral character and a basic knowledge of the English language and U.S. history, and be willing to take an oath of allegiance to the United States.

Legal Permanent Resident (LPR): Commonly referred to as "green" card holders, persons who have been granted permission to stay in the U.S. indefinitely as residents

Refugees/Asylees: person who flees his or her country of origin due to a well-founded fear of persecution based on religion, race, political opinion, nationality or membership in a particular social group. Refugees apply for this protection abroad. Asylees apply for this status once they are in the U.S.

Withholding of Removal: permission granted during removal (deportation) proceedings to immigrants who can demonstrate a substantial threat to life or liberty if returned to their country of origin

Cuban and Haitian entrant: In general, refers to Cuban and Haitian arrivals who, in 1980, were given permission to enter the Country and obtain employment authorization and public assistance. For the purposes of eligibility under welfare "reform", the term is applied to Cubans and Haitians who have been granted special status as entrants, those applying for asylum, those granted parole or those in removal proceedings.

Parolee: person allowed to enter the Country for humanitarian, legal or medical reasons, who is granted Parolee status for a certain amount of time during which (s)he has legal permission to reside in the Country. This type of permission is discretionary.

PRUCOL: acronym for Permanently Residing under Color of Law. PRUCOL is not an immigration status. It is a public benefits determination. It implies that an immigrant is in the Country with some type of permission, since the immigrant is both known to the INS and the INS has not moved to deport him or her. Examples of immigrants considered PRUCOL include asylum applicants, adjustment of status applicants and persons granted

extended voluntary departure. PRUCOL has been interpreted differently by different public assistance programs.

Diversity Visa Lottery: 55,000 visas allotted annually to persons from countries with low admission rates to the U.S. A person who applies for the lottery must meet the Country's eligibility requirements as well as the education or work experience requirements. An immigrant who "wins" the lottery wins the chance to apply for a "green" card. (S)he does not "win" a "green" card. The "winners" of the lottery are selected at random. The information from non-winners is destroyed annually. Only one application per immigrant is accepted by the Department of State; otherwise, the immigrant is automatically disqualified.

The Latino Commission on AIDS is a non-profit organization dedicated to improving and expanding AIDS prevention, research, treatment and other services to the Latino community through organizing, education, program support, training and other services.

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