

HIV Prevention Service Needs for Immigrants in New York City

Needs Assessment and Gaps Analysis Report **Final Report** *November 2004*



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INTRODUCTION

ECQ Group, Inc., a non-profit technical assistance agency serving New York State organizations, has developed this report under contract with the New York City Department of Health and Mental Hygiene (NYC DOHMH) in response to a request from the NYC HIV Prevention Planning Group's Immigrant Workgroup to conduct a needs assessment and develop a Resource Directory. The purpose of these tools is to help improve access and availability of HIV prevention services for immigrants, and to identify the current gaps in HIV prevention service needs for immigrants in New York City. The report documents the unmet HIV prevention service needs of immigrants, with particular attention given to populations that are considered of highest risk. Seven information-gathering methodologies informed the report and recommendations. It is our hope that the findings of the report will be useful for service providers in program planning, need justification, fundraising, and community education.¹

ECQ Group, Inc. gathered information from May through October 2004 through advisory meetings with NYC DOHMH and Prevention Planning Unit (PPU) staff, Prevention Planning Group (PPG) Immigrant Workgroup members and additional guests from the immigrant community; a focus group of 15 participants with extensive experience in HIV prevention work with immigrant populations, half of whom were immigrants themselves; and four key informant interviews. ECQ Group, Inc. held additional meetings and telephone conversations with NYC DOHMH PPU staff to further solidify the approach and refine the process.

Through this process, ECQ Group, Inc. developed a survey tool and identified a list of HIV prevention and immigrant service agencies. The main purpose of the survey was to collect information for the Resource Directory. Additional key questions helped inform the needs assessment and gaps analysis report. The four page survey was distributed to over 200 currently funded HIV prevention agencies and immigrant service providers. Agency staff had difficulty responding to all the questions, particularly those questions which asked for percentages in relation to service provision,² which are the questions that most informed the needs assessment. The additional information gathered through primary and secondary data collection strongly informed the process, including telephone follow-up, anecdotal information from key informant interviews, and the extensive literature review.

NYC DOHMH requested agencies to provide needs statements about the provision of HIV prevention services for immigrants; however, only three agencies were able to provide such statements. Many agencies responded that they have not developed a justification of need for this specific service area and population. Additional information gathered during telephone conversations further informed the analysis.

¹ ECQ Group, Inc.'s mission is to help health and social service organizations survive and thrive by providing management support, technical assistance and training.

² Questions # 3, 4, 6 were specific to the gaps analysis, but were difficult for many agencies to complete. A copy of the survey is in Appendix A.

ECQ Group, Inc. conducted a review of the professional literature and a review of funded programs. It was found that of the approximately 300 community-based organizations serving immigrants in New York City, few, if any, are targeted specifically for immigrants with HIV.

Throughout the numerous meetings, conversations and research, a few key common themes emerged. These include: the importance of legal services; the need for culturally and linguistically appropriate materials; the need for trainings; housing as a paramount issue; and the need to improve early access to HIV primary care and general medical care. In addition, more resources need to be devoted to peer education programs, community-based interventions, train-the-trainer programs, and research and evaluation.

BACKGROUND

The United States has been a haven for immigrants seeking political freedom and a better quality of life. A record-breaking one million immigrants have entered New York City over the past ten years.³ This is an increase of nearly 38% during the 1990s. Although NYC constitutes less than 3% of the U.S. population, it receives 14% of all immigrants to the US.⁴ In fact, one in three New Yorkers is born outside the US, well above the national average of 11%.^{5, 6} New York has the most diversity among it's foreign born, with Caribbeans representing 30%, Asians 24%, Europeans 19% and South Americans 14%. Specific countries with the most new immigrants to New York in the year 2000 include: the Dominican Republic, China, Jamaica, and Guyana.⁷

In 1999, The Department of City Planning released *Newest New Yorkers 1995-1996: An Update of Immigration to the City in the Mid '90s*. The information that follows is from this report. During the two year period 1995-1996, over 231,000 immigrants settled in NYC, a 2.7% increase from the average in the early 1990s. Refugees accounted for the increase in immigration, due to those entering under the "diversity" provisions of immigration law, which were enacted to increase underrepresented groups. As a result of this "diversity program," for the first time, African countries including Ghana, Nigeria and Egypt emerged as major sources of immigrants. Similarly, close to one-half of Bangladeshis entered under the diversity program and as a result, Bangladesh is now the sixth largest source of immigrants to the city.

Relative to the nation, New York City gets a high share of Caribbean immigrants, who constituted 33 percent of the flow to the city but only 12 percent of immigrants to the U.S. as a whole.⁸ During the early 1990s, the Dominican Republic averaged 22,000 annually, and accounted for one in five immigrants. The Mexican population has witnessed dramatic increases in the period between 1990 and 1996, largely due to high fertility rates and internal migration. During this period, there were nearly 29,000 births to Mexican-born mothers, making Mexicans the third largest Hispanic group in the city after Puerto Ricans and Dominicans. Among foreign-born mothers, only Dominicans and Jamaicans exceeded the Mexican birth rate.

During this same time period, the former Soviet Union experienced the largest increase of any major source country, from an annual average of 1,300 immigrants in the 1980s to 13,300 in the early 1990s. As a result, the former Soviet Union accounted for nearly

³ Voices from the Field, Building Bridges and Removing Barriers: A Strategy to Promote the Self-Sufficiency of New York's Immigrant Communities. The United Way of New York City. p.8.

⁴ VOICES: An Assessment of Needs Among Asian and Pacific Islander Undocumented Non-Citizens Living with HIV Disease in New York City (October 2000). Memorial Sloan-Kettering Cancer Center. p.4.

⁵ New York in Focus: A Profile from Census 2000 (2003). Brookings Institution Center on Urban and Metropolitan Policy.

⁶ Health Disparities in New York City (2004). New York City Department of Health and Mental Hygiene.

⁷ New York in Focus: A Profile from Census 2000 (2003). Brookings Institution Center on Urban and Metropolitan Policy.

one in eight immigrants to the city, making it the second largest source country of immigrants to NYC. Immigration from the Soviet Union appears to have tapered off in the later 1990s, in comparison to immigration from other countries.

Asia accounted for one quarter of the immigration since the early 1990s. China, which includes the mainland, Hong Kong, and Taiwan, has consistently been the third highest source of immigrants since the early 1970s, averaging 11,900 immigrants per year.

The largest Asian groups were Chinese (374,231, not including Taiwanese), Asian Indian (206,228), Korean (90,208), Filipino (62,058), and Pakistani (34,310). Sixteen Asian population groups were listed separately, with a significant 24,088 grouped under "Other Asian." Asian and Pacific Islanders (A&PIs) came from 20 countries comprising 49 ethnicities and speaking over 100 languages. Seventy-eight percent of the total NYC Asian population was foreign-born (compared to 36% of the city's foreign-born residents).⁹

Overall, recent immigrants are younger than the general population (median=27 years). Thirty-five percent of all immigrants arriving during 1990-1994 settled in Brooklyn, 30% settled in Queens, 20% settled in Manhattan, 14% in the Bronx and 2% in Staten Island. The Dominican Republic alone accounted for 40% of the flow to the Bronx and to Manhattan while immigrants from the former Soviet Union comprised one-quarter of the flow to Brooklyn. While no country dominated the flow to Queens or Staten Island, China was the largest sender, accounting for 12% of the flow to Queens and 11% to Staten Island.¹⁰

The top three immigrant-receiving neighborhoods in the city during 1990-1994 were Washington Heights (28,800), Chinatown and vicinity (19,120) in Manhattan, and Gravesend-Homecrest (15,800) in Brooklyn. In addition, the Queens neighborhoods of Flushing, Astoria, Elmhurst, Corona and Woodside each received more than 10,000 immigrants during this period.¹¹

With the large numbers of immigrants in New York City, English is often the second language, if spoken at all, with 22% of the New York City population having limited English proficiency.¹²

Historically, periods of restrictive immigration policies follow periods of immigration. In 1996, the Illegal Immigration Reform and Responsibility Act (P.L. 104-208) and the Personal Responsibility and Opportunity Reconciliation Act (P.L. 104-193) were signed and passed. These two new laws, in addition to the Anti-terrorism Act, marked the most sweeping changes in the immigration system since the mid 1960s and the most

⁹Statement of Need (August, 2004). Asian & Pacific Islander Coalition on HIV & AIDS.

¹⁰ The Newest New Yorkers: 1990-1994 Executive Summary. Department of City Planning. p.3.

¹¹ Ibid.

¹² New York Task Force on Immigrant Health, as reported by the Immigration Planning Group of the HIV Planning Council of New York (January 2002).

restrictive since the 1920s.¹³ Some of the more draconian changes that ensued were: stricter eligibility for access to cash assistance, health insurance and food stamps, limited eligibility (TANF) to a lifetime maximum of five years (December, 2001) and legal immigrants' exemption from obtaining food stamps and SSI. As stated by Dr. Cordero-Guzman:

Immigrants entering the U.S. after August of 1996 were excluded from participating in most federal means-tested programs for the first five years and states were allowed to exclude legal immigrants from major federal and state programs. Other changes imposed new requirements and increased the responsibility of the sponsors by making "affidavit of support" legally enforceable, expanded sponsor-deeming requirements and lengthened the amount of time income would be deemed. Lastly, the new legislation explicitly excluded undocumented persons and non-immigrants from programs and required the INS to verify the status of immigrants who applied for federal public benefits.¹⁴

Documentation requirements also present barriers due to both lack of documentation, and/or fear about connections to INS and future harm or deportation.¹⁵ The result of these restrictive policies was to drive undocumented immigrants further underground.

The impact of September 11th has further distanced immigrants from accessing HIV prevention and care services and benefits. Additional restrictive policies have been enacted, including racial profiling, heightened homeland security measures, anti-immigrant sentiment in many places, and increased deportation.¹⁶

¹³ Cordero-Guzman, Ph.D. (May 2000). What Do Immigrant Service Providers Say About the Impact of Recent Changes in Immigration and Welfare Laws. *Migration World Magazine*. v28, i4, p20.

¹⁴ Ibid.

¹⁵ Report: Crosscutting Issues, Racial and Ethnic Minority Populations, Access to HIV/AIDS Care Issues, Community Consultations (January 28-February 3, 2004). Health Resources and Services Administration HIV/AIDS Bureau.

¹⁶ Ibid.

IMMIGRANTS AND HIV IN NEW YORK CITY

More than one-third of New York City's population is foreign-born, and 6,082 immigrants living with AIDS reside in New York City.¹⁷ Immigrants accounted for 10-12% of AIDS cases from 1992 to 1998. The AIDS case rate among immigrants in NYC is 575/100,000. The origin of immigrants living with AIDS in NYC includes 119 countries around the world. NYC DOH Office of AIDS Surveillance reported in 2000 that about 66% (nearly two thirds) are from three regions: the Caribbean (40%), Central America (13%), and South America (12%). This continues to hold true in September 2003, with two thirds (64%) of the immigrants living with AIDS originating from 16 countries (chart below), which, with the exception of Italy, India and Germany, fall within these same three regions.¹⁸ **Because of issues of immigration status, and the mobility of recent immigrants, there are no data available to show the overall distribution of immigrants living in NYC.**

Immigrants Living with AIDS in NYC by Country of Origin

	PLWHA, Sept 2003 ¹⁹		PLWHA, June 1999 ²⁰		% Change
Haiti	1276	23%	873	29%	+46%
Dominican Republic	875	16%	427	14%	+105%
Jamaica	470	9%	240	8%	+96%
Colombia	394	7%	175	6%	+125%
Trinidad/Tobago	359	7%	160	5%	+124%
Mexico	340	6%	182	6%	+87%
Guyana	257	5%	90	3%	+186%
Ecuador	249	5%	137	5%	+82%
Cuba	247	4%	165	6%	+50%
Honduras	239	4%	130	4%	+84%
Brazil	222	4%	119	4%	+87%
Venezuela	148	3%	71	2%	+108%
Peru	118	2%	53	2%	+123%
India	111	2%	N/A	N/A	N/A
Panama	97	2%	66	2%	+47%
Italy	96	2%	57	2%	+68%
Germany	N/A	N/A	50	2%	N/A

¹⁷ Update to the 2002 Needs Assessment (July 2004). Prepared by McClain and Associates, Inc. New York HIV Health and Human Services Planning Council.

¹⁸ New York City HIV Prevention Plan 2000, Volume 1. New York City Department of Health.

¹⁹ People Living with HIV/AIDS (PLWHA) at the end of September 2003 by Country of Origin (November 2004). New York City Department of Health and Mental Hygiene.

²⁰ Data reported as of June 30, 1999, in New York City HIV Prevention Plan 2000, Volume 1. New York City Department of Health Office of AIDS Surveillance.

CURRENT NEEDS AND SERVICE GAPS

Social service programs are vitally important to the immigrants who are invigorating New York City's economy and culture, according to a report by United Way of New York City (UWNYC). Successful immigrants are the key to the City's future, and social service programs are the key to immigrant success. *Building Bridges and Removing Barriers*²¹ reveals that immigrants from all corners of the world are pouring into New York City in unprecedented numbers. Over the past 10 years, one million new Americans have settled in the city's five boroughs, filling New York's labor needs, invigorating our commercial strips, and rejuvenating our population. Immigrants currently make up 35-40 percent of the city's residents, the largest percentage ever. However, many of these newcomers remain trapped in the lowest paying service sector jobs, which prevents them from achieving economic independence and moving up the ladder to better paying jobs.

Social service agencies, public officials, and immigrants consulted during UWNYC's comprehensive study, pointed to three main handicaps that impede the progress of today's immigrants: lack of English language skills; unfamiliarity with the city's human service and economic systems; and legal problems.

Learning English is the most important step toward breaking the chains of dependence. Language barriers can prevent parents from getting involved in their children's education. They also inhibit the use of city services, and drastically limit employment opportunities. Immigrants also tend to be unfamiliar with city's social service organizations that can serve as a bridge to a brighter future. More aggressive outreach to immigrants to help them learn how to use available services to their advantage will require additional staffing for social service groups that serve large immigrant populations.

Immigrants also regularly deal with many exhausting legal issues that are either directly related to their immigrant status, as a result of the 1990 Immigration Act, or civil issues, which are seriously complicated by their status. Many immigrants cannot afford proper legal services. The report stresses the need for funding to create and develop free professional legal services within immigrant agencies.

To help resolve these problems, there is a pressing need for increased private and federal funding to strengthen community-based immigrant provider organizations. While New York contains more than 300 nonprofit organizations serving the myriad foreign-born communities of the city, most of these organizations - particularly those which are grassroots - operate in isolation, on single-contract budgets, with minimal staff, and little or no financial or fundraising experience.

²¹ Voices from the Field, *Building Bridges and Removing Barriers: A Strategy to Promote the Self-Sufficiency of New York's Immigrant Communities*. The United Way of New York City. p. 8.

The report concludes that the city's community-based groups need assistance in building their administrative and staff capacities, diversifying funding streams, acquiring fiscal expertise, and building relationships with the city's government, philanthropic and nonprofit sectors. **Few, if any of the approximately 300 community-based organizations serving immigrants in New York City are specifically targeted to serve immigrants with HIV.**

The Center for Women in Government & Civil Society & Family Planning Advocates of New York State reported numerous barriers facing immigrant women in *Working Together to Increase Immigrant Women's Access to Reproductive Health Care*.²² These barriers are similar to those facing women accessing HIV prevention and care services and include:

- X Lack of community education about available services
- X Lack of linguistically-competent [reproductive health] services
- X Use of male relatives as interpreters
- X Male domination and lack of personal decision-making power
- X Intersection of domestic violence and gender power imbalance with access to [reproductive health] services
- X Fears of deportation and detention about 9/11
- X Lack of health insurance
- X Inflexible health clinic hours
- X Lack of culturally sensitive services, negative attitudes of front-line health workers and insensitivity to the unique challenges facing immigrant women.

Provider barriers include:

- X Health workers untrained in the provision of culturally-competent services
- X Lack of staff members who reflect the demographic/ethnic diversity of immigrant communities
- X Ineffective outreach to immigrant women
- X Difficulty retaining staff members that reflects a continually changing community
- X Insufficient funding to reimburse provider costs for delivering culturally and linguistically appropriate services
- X Language barriers which obstruct communication with patients, particularly the use of male relatives [or children] as interpreters
- X Under-representation of immigrant community members at local and state decision-making tables

To overcome some of these barriers, the report recommends peer education; immigrant serving organizations to serve as cultural educators of providers; strengthening partnerships between providers and community-based immigrant serving program; targeting outreach in non-traditional settings; making information more readily available; hiring staff who reflect the community; and providing appropriate training.

²² Working Together to Increase Immigrant Women's Access to Reproductive Health Care. Report on Statewide Roundtable (December 2002). Center for Women in Government & Civil Society & Family Planning Advocates of New York State. pp 5-6.

Participants at the *HIV and Immigrants: Access to Care Conference* held at Elmhurst Hospital in Spring, 2001 noted the importance of legal aid services, culturally and linguistically appropriate materials, and training of service providers throughout the conference. They also identified the following service gaps:

- Radio campaigns and contacts with journalists at local newspapers
- Support groups for African immigrants
- Long waiting lists
- Language barriers
- Need for more prevention programs
- Lack of affordable housing
- Legal services
- Transitional Housing
- Mental Health (language capacity)
- Transportation
- Home Health Care
- Child care
- Food pantries

The *New York State Department of Health AIDS Institute's Community Forums*²³ held in November 2000 identified undocumented individuals as a key population to focus on when addressing prevention and health care for women. The report states:

HIV prevention/education and health care are not primary concerns for this population which faces many barriers to care, including: immigration and family re-unification issues, denial, cultural beliefs and use of alternative treatments, discrimination and homophobia, lack of housing, fear of disclosure and partner notification, lack of skills to negotiate safe sex (economic issues), fear of the system, etc. There is a need to train gate keepers in immigrant communities, to support and assist individuals with partner notification, and to educate the community using local media.

ECQ Group, Inc. queried over 200 agencies that currently provide HIV prevention services and/or immigrant services to determine the populations served throughout New York City, and the agencies' ability to serve undocumented immigrants. According to survey respondents:

X Twenty-six percent of survey respondents provide HIV prevention services for immigrants in the Bronx, 47% in Brooklyn, 29% provide services in Manhattan, 21% in Queens and 8% in Staten Island.

²³ Community Forums on HIV Prevention and Health Care for Women, Children, Families and Young People: Key Findings (November 2000). NYS Department of Health AIDS Institute, Bureau of Special Populations, Bureau of HIV Ambulatory Care Services.

X Approximately 79% of responding agencies provide HIV prevention services to Latino immigrants, 68% provide services to Caribbean immigrants, 46% to African immigrants, 7% to Asian and Pacific Islander immigrants, and 7% provide HIV prevention services to Caucasian immigrants.

X Almost all responding agencies reported that they have the ability to serve the undocumented.

During 2003, ECQ Group, Inc. conducted Regional Gaps Analyses (RGA) throughout the five boroughs of NYC on behalf of the New York State Department of Health AIDS Institute Prevention Planning Group. The findings from the six immigrant focus groups conducted as part of the RGA are included in this analysis.

The *Manhattan Regional Gaps Analysis* completed by ECQ Group, Inc. on behalf of New York State Department of Health AIDS Institute Prevention Planning Group (NYS PPG) also pointed to the ongoing obstacles of “fear, stigma, social isolation and denial” as a barrier to HIV counseling and testing.²⁴ Participants stated that “behavioral science based counseling (stages of change) places emphasis on the individual and doesn’t address stigma and discrimination...Moreover, the Risk Targeting Model [used by the DOHMH NYC PPG] doesn’t take into account the cultural context in which HIV infection occurs.”

Manhattan participants also identified current policy decisions as a result of 9/11 as inhibiting prevention and care seeking. These include restrictive immigrant policies, racial profiling, and the subsequent unemployment and poverty in immigrant communities. The participants also reported a lack of housing for undocumented immigrants as an ongoing problem.

One of the immigrant focus groups held as part of the *NYSDOH PPG Regional Gaps Analyses* identified a need for increased education for the general community. Participants in this group also believed that HIV testing was only available if you had insurance and proof of identification, both barriers for immigrants. The focus group also noted the lack of language capability to serve African immigrants on Staten Island.²⁵

The *New York City HIV Care Networks* regularly conduct needs assessments and develop service plans. The Bedford Stuyvesant/Crown Heights HIV Care Network noted immigrant issues in their Year 2000 Service Plan Update.²⁶ They reported that concrete epidemiologic data is difficult to secure for non-US born individuals. They noted the need for conducting a needs assessment to gain more information about where immigrants are accessing social and health care services They also noted the

²⁴ NYS Regional Gaps Analysis, HIV Prevention Planning in Manhattan. Discussion Group Final Report (December, 2003). New York, New York.

²⁵ NYS Regional Gaps Analysis, African Immigrant Discussion Group on HIV Prevention. Summary of Discussion Group (May 16, 2003). New York, New York.

²⁶ Bedford Stuyvesant/Crown Heights HIV Care Network Year 2000 Service Plan Update.

hurdles and barriers recent immigrants face when attempting to obtain services, including residency requirements, and fear of deportation which limits service utilization.

LACK OF FUNDING

A survey by Funders Concerned About AIDS, a New York group, reveals a 21% decline in the number of donors making HIV or AIDS grants since 1997. The study, which involved 276 foundations and corporate givers, also found that the number of grants of \$50,000 or more dropped 22% in the same period. In addition, the 1998 Foundations Grant Index shows that private foundation funding for AIDS prevention, treatment, and research dropped \$7 million in 1997 from \$37 million in the previous year. By all indications, small gifts are declining as well. Analysts attribute the drops in giving to misinterpretations that AIDS has become a “manageable disease,” as well as donor fatigue.”²⁷

Foundation giving to US nonprofits reached \$19.46 billion in 1998, exceeding by 22% the then-record 1997 level of \$15.98 billion. However, AIDS-related organizations did not fare as well as others; just \$30 million of nearly \$16 billion in foundation grants awarded in 1997 went to HIV/AIDS causes, \$7 million less than in 1996. Grants from both foundations and corporations declined in 1998 despite news that new HIV cases in the US are once again on the rise.²⁸

Federal AIDS funding had seen a heartening 17% increase in the late 1990s, however, this has changed over the last four years, with serious struggles each year to maintain a federal focus on addressing HIV and AIDS in the United States.

Some governmental agencies have severely restricted the ability of community-based agencies to develop prevention materials that appropriately target and deliver an effective message. In addition, governmental funds are often reallocated to other geographic areas, agencies and or populations after a three year contract. This limits the programs’ impact by ending it often just when the program has become an integral part of the community’s service structure.

²⁷ Queens AIDS Fact Sheet (2001). Brooklyn AIDS Task Force. p.4.

²⁸ Ibid, p.12.

IDENTIFIED SERVICE NEEDS

Outreach: Outreach to immigrants is a critical component for prevention education and case finding. There is a strong need for a media campaign (flyers, posters, television and radio) in the target population's native language. Bus stops and train stations are the most effective locations to place these campaigns. More labor intensive forms of outreach to immigrants include door-to-door street outreach in housing projects, social clubs, factories and other workplaces (restaurants, street vendors, garages). Suggestions for non-traditional outreach venues included health fairs, concerts, migrant worker stops, day care centers, shelters and food pantries. The need to collaborate with local churches, medical providers, legal service providers and community based organizations is critical to the success in engaging immigrant clients who might be at risk for HIV/AIDS. Other suggestions included the creation of a language bank shared by social service agencies, educational videos and pharmaceutical literature in languages other than Spanish.²⁹ One hospital reported that the increasing availability of and knowledge about immigrant services has helped decrease the use of the hospital emergency room. Moreover, the immigrant's health status improved and hospital costs decreased.

HIV counseling and testing: The availability of HIV counseling and testing services to immigrants is key, as a point of access for prevention education and medical care, and needs to be integrated. Providers and consumers must understand the implications of HIV testing upon one's immigrant status, including the distinction between anonymous and confidential HIV testing. Traditional models do not work, particularly for HIV counseling and testing. The immigrants need to hear from their peers the importance of being tested, and what finding out about their HIV status will mean for them.

Accessing Services: While providers knew of current services available to immigrants, they stated that often clients were not aware of these services. In addition, long waiting lists and limited capacity make it difficult to refer clients for services in a timely manner. The Asian and Pacific Islander Coalition on HIV & AIDS (APICHA) and AIDS Center of Queens County (ACQC) both reported in their needs statements that many immigrants do not seek medical care until it is very late, "often as they begin experiencing serious opportunistic conditions related to HIV disease."³⁰ APICHA also reports that Asian and Pacific Islanders (A&PIs) seek care very late. They report that the 2003 NYC DOHMH surveillance report states, "Of the 39 HIV diagnoses, 10 were concurrent AIDS diagnoses, which means that the infection progressed to AIDS within 31 days of HIV diagnosis."³¹

Need for additional supportive services: There is a need to identify additional supportive resources for HIV+ immigrants, beyond medical services, especially with the large growth in numbers and diversity of immigrant communities within New York City.

²⁹ Designing Programs for HIV Prevention and Care for Immigrant Populations. Elmhurst Conference (Spring 2001).

³⁰ AIDS Center of Queens County Needs Statement (August 2004).

³¹ Asian & Pacific Islanders on HIV & AIDS Needs Statement (August 2004).

This includes immigrant specific services regardless of legal status, such as legal support available at the time the person finds out he/she is HIV-positive, housing, and emergency assistance. Providers responded that legal services and mental health services are a critical part of HIV prevention services for immigrants. Stigma about accessing mental health services further hampers abilities to provide this service. Key informants report that alcohol is the key drug in the immigrant population, and that alcohol and drug prevention and treatment must be part of HIV prevention. Without addressing alcohol and substance abuse, people will continue to be intoxicated and make poor sexual decisions.

Additional important services include housing, food and nutrition, drug treatment/substance abuse, ESL/literacy, domestic violence programs, emergency funds, burial expenses and custody planning for immigrant children. Very basic survival services are desperately needed and often unavailable through the current funding streams, especially Ryan White.

Legal services: The need for legal services is great, and there is a concurrent need for provider training on legal issues. There is an unmet need for in-depth legal services for immigrants and undocumented individuals who are at risk for HIV or HIV-positive, especially in light of tighter immigration policies and procedures post 9/11. As stated in the needs statement from AIDS Center of Queens County (ACQC), "Delays in receiving proper care, which for many immigrants is due to their legal status, can lead to opportunistic conditions becoming life threatening. Advocacy then to regularize immigration status is literally for many immigrants living with HIV/AIDS, a matter of life and death." Very few groups in NYC were identified by providers who currently offer in-depth legal services for individuals at risk for HIV/AIDS. The HIV Planning Council's Immigration Planning Group noted a need for annual basic immigration law and eligibility training for agency staff due to high staff turnover and ongoing changes in immigration issues.³²

TRUST, DISCLOSURE AND CONFIDENTIALITY: Fear of lack of confidentiality, disclosure, and stigma keeps many immigrants from seeking services. These fears are based on the reality of potential deportation, community or family taboos around HIV and AIDS, and values about assumed behavior. These barriers can be especially large for newer immigrants, such as Mexican and Dominican women, and West Africans.

Trusting relationship: A relationship based on trust is necessary before discussing a sensitive issue that is taboo, such as HIV and AIDS. Providing services through peers, or developing an agency with a strong track record in providing services to immigrants can be key. When evaluating prevention programs, one must account for the time needed to develop a trusting relationship. In this context, it may be noted that New York City HIV Prevention Plan 2000, (Vol. 1:173) has recommended several general intervention principles, critical for effectiveness of interventions.

³² New York City HIV Health and Human Services Planning Council. Social Services Workgroup, Immigration Planning Workgroup. Report and Recommendations from 1/22/02.

Fear of government: One of the major findings in *South Asian Immigrant Women's HIV/AIDS Related Issues: An Exploratory Study of New York City*,³³ relates to the great fear among community members to use government services because of reported information sharing that has taken place among government agencies. These government policies create barriers to care. Both policies and fear may have intensified after September 11th, with immigrants now being deported for what was previously a minor infraction. This fear is especially intense among the South Asian communities as they are among the most heavily impacted by the policies.

IMPACT OF CULTURE ON HIV PREVENTION:

Cultural barriers: In addition to the barriers related to poverty for many new immigrants to New York City, immigrants also often face social, cultural and language barriers. The Asian & Pacific Islander Coalition on HIV & AIDS (APICHA) Needs Statement noted the depth of cultural barriers, which is shared by other ethnic groups:

Discussion of sex and substance use is discouraged in most A&PI cultures. Homosexuality is considered shameful and a threat to the continuation of "traditional" family lines. Many A&PIs believe that same-sex relationships are a Western phenomenon that does not exist in their communities. Furthermore, A&PIs rarely discuss issues related to dying. A&PIs with terminal illnesses are often not told about their disease or prognosis as discussion about death is thought to cause psychological distress that makes people give up on life. For A&PIs living with AIDS/HIV, shame about their illness and how they were infected, may be compounded by guilt. They "lose face" and feel unworthy of receiving help. A&PI community leaders, themselves firmly entrenched in denial, are often reluctant to take on the community-wide stigma associated with AIDS and, by their inaction, perpetuate the silence around the epidemic.³⁴

Unprotected sex: Cultural norms can greatly impact HIV prevention efforts. As reported in APICHA's needs statement:

In a study conducted in 2001 by Hirokazu Yoshikawa, Ph.D., Ezer Kang, Ph.D. et.al.³⁵ "norms of unprotected sex" retained from countries of origin is identified as one of the factors associated with HIV risk. East Asian, Southeast Asian, and South Asian cultures commonly practice unprotected sex, which is often considered a higher form of intimacy. Condom use is also associated with promiscuity or having STDs, thus

³³ Abraham, M. PhD, et. al., prepared for the Department of Health and Human Services (August 2004).

³⁴ See Eckholdt, H., et al., *The Needs of Asians and Pacific Islanders Living with HIV in New York City*. (November 1997). AIDS Education and Prevention; and Yoshioka, Marianne, et al., *Disclosing Status and Accessing Social and Institutional Support: HIV+ Asians and Pacific Islanders in New York City* (1996). Poster presented at the XI International Conference on AIDS, Vancouver, Canada.

³⁵ HIV Prevention Needs Assessment of Asian/Pacific Islander Men Who Have Sex with Men in New York City. New York City Department of Health. Unpublished.

A&PI women succumb to unprotected sex to avoid being stigmatized. Immigrants who tested negative upon arriving in the United States perceive themselves as a low-risk, especially when they have had anal intercourse with multiple sex partners in their home country... Many immigrants come from regions in Asia and the Pacific Islands where HIV prevention may be non-existent or scarce. Healthcare and social services providers therefore must keep pace with the needs of new arrivals and those who have established deeper roots in the city.”

Use of cultural mediums. Use traditional cultural mediums such as art, music, and dance to deliver HIV prevention messages.

GENDER AND SEX APPROPRIATE PREVENTION SERVICES:

Gender and sex appropriate services: Especially for the immigrant population, there is a need to provide HIV prevention services in a way that targets sex and gender issues separately. These models must be sensitive to the specific cultural norms, providing different prevention modalities for women and men. Women have family based issues, as they are often still living with extended family members. Men are often here alone, living in close quarters, not in their native surroundings, and sometimes see prostitutes. MSM activity is not necessarily homosexual (non-gay identified), and may be occurring in a community where it occurs in a very secretive and isolated way. It is also important that undocumented men be recognized as a specific targeted population, as they need to be aware of their ability to infect others, including their wives and partners.

Gender roles: The dynamic of “Machismo” exerts a large role in HIV prevention, and is perhaps best explained in the APICHA Needs Statement: “A dynamic similar to “Machismo” also exists in some A&PI communities, putting women at risk for HIV when they are in relationships with men who are having sex outside of their primary relationship. Women are viewed as secondary with little power to question or change the behaviors of their male partners. This can lead to disempowerment and domestic violence, it plays important roles in sexual decision-making, and it can ultimately increase risk for STDs and HIV.³⁶ Many of these women are found through domestic violence centers.”

LANGUAGE CAPABILITIES AND TRANSLATION SERVICES:

Impact of Limited English Proficiency (LEP): One of the major challenges for non-English speaking immigrants is their inability to communicate about health issues. This is a major challenge, especially for some A&PIs. “Twenty-eight percent of adult [A&PIs in NYC] 18

³⁶ Bower HM, et al. Intimate partner violence and high risk sexual behaviors among female patients with sexually transmitted diseases (July 2002). Journal of Sexually Transmitted Sex Diseases. 29(7):411-6.

to 64 years old and 61% of people 65 years and older were LEPs in 2000.”³⁷ The study found that in Chinatown in 2002, 42% (34,474) of the area’s adult residents had LEP. This is compared to the NYC rate of 26%. This greatly impacts on their ability to seek, access and utilize services.

Language capability and interpretation: There is a service gap for multi-lingual staff, particularly health care professionals. One provider discussed the need for additional Spanish speaking providers. APICHA reported in their needs statement, “The ability of New York City’s mainstream providers to provide appropriate language interpretation is woefully lacking. Many hospitals do not have staff members who speak A&PI languages, or if they do, they often do not have the knowledge and understanding of the patients’ cultural values and practices essential to effective communication.”

AGENCY CULTURE: The agency setting is key to reaching and engaging immigrants, and retaining them in HIV prevention services.

Immigrant friendly agency: Immigrant providers need to create a space that is welcoming and professional, as well as a setting that is non-stigmatizing and protects confidentiality. Providers described an agency as immigrant friendly if immigrants work there, if it offers culturally appropriate materials, and if it provides client-centered services. Delivery of the HIV prevention message must be sensitive to the needs of immigrants with low literacy levels. The Latino Commission on AIDS in its report *HIV Prevention Services for Immigrant and Migrant Communities* has produced a list of 25 actions that an agency can take to make their services more “immigrant friendly.” A copy is included as Appendix C.

Expertise in serving immigrants: Expertise in providing services to immigrants is essential. Providers identified an agency as having expertise if at least 50% of their population served is immigrant.

STAFFING RECRUITMENT AND TRAINING: It is necessary to provide culturally and linguistically sensitive and appropriate services. To do this, it is necessary to hire and train staff appropriately.

Hire appropriate staff: Hiring staff who reflect the client population being served engenders trust. HIV prevention will be more effective if the messengers are immigrants themselves or individuals who understand the immigrant experience. Of the agencies providing HIV prevention services to immigrants that provided information about the percent of their staff who are immigrants, it was found that 43% have a majority of immigrant staff (at least 60%), and 30% have some immigrant staff (20-60%).

³⁷ Chinatown After September 11th: An Economic Impact Study (April 2004). Asian American Federation of New York.

Providing linguistically appropriate services entail recruiting frontline staff who not only speak languages widely spoken by one's client population, but staff who also understand the cultural nuances unique to one's client population. It will be necessary to hire professional translators and interpreters if a staff person who speaks the client's language is not available. This will insure accuracy and, most importantly, help maintain patient confidentiality by not using the patient's family members or friends as translators.

Ongoing staff training: In order to underscore the importance of delivering services in a culturally competent manner, agencies need to make a commitment of training staff agency-wide and at all levels about immigration and HIV prevention.

Improve retention: More resources must be made available to improve staff salaries in an effort to remain competitive, improve retention, and maintain client relationships.

SERVICE INTEGRATION: HIV prevention assessment and education services need to be integrated into other basic services to be effective. The timing of HIV prevention assessment and services is an important aspect related to effectiveness, and there is a need for additional related services.

Increasing informal outreach and education. There is an unmet need to provide HIV prevention services before people are infected. This includes increasing informal community outreach and education to reach more people and bring them into care and services, and to incorporate HIV prevention into services that immigrants' access. Informal outreach includes cross training the people who are currently working with immigrants to teach them about other services available for their clients, and incorporating HIV prevention into their work.

Access to services: HIV prevention services are most accessible and effective when provided within the context of a variety of services that address immigrant's basic needs. Services need to be provided at service entry points, including immigration service agencies (not HIV-specific), medical sites including STD, medical and substance use service sites. To avoid stigma, HIV prevention services need to be where immigrants access other services, rather than at an HIV-only service site.

Context of service provision: Recognizing immigrants' total hierarchy of needs is critical and must include addressing the survival of immigrant families and their ability to negotiate systems. When conducting HIV prevention assessment with immigrants, it is important to recognize that other needs take higher precedence over risk for HIV/AIDS. Therefore, in order to design effective prevention strategies, one must take into account the realities faced by immigrants and provide an integrated model that includes case management, services that allow for basic survival needs, and legal services.

NEED FOR BASIC MEDICAL SERVICES:

Primary care for non-HIV infected is essential. There is an unmet need to provide disease prevention, including the ability to test for multiple diagnoses, provide vaccinations, and integrate health education and testing.

Basic medical services need to be available for immigrants: Child Health Plus has made a big difference for the children in immigrant families. Family Health Plus should be available for ALL undocumented immigrants. Their basic medical needs are large, especially within the context of a historical lack of access to health care. Increasing awareness about Child Health Plus and Medicaid is essential as some immigrants are not aware of the programs, or of their children's eligibility. There is also great fear that the information provided to enroll in these programs will be used to deport them or be used against them in the future.³⁸

INTERAGENCY ISSUES:

Need stronger ties between HIV service providers and immigrant service providers. The changes of reaching immigrants increase significantly when immigrant service providers and HIV service providers work together collaboratively, especially when trying to reach those at higher risk. The first step to successful intervention is to develop stronger ties between HIV service providers and immigrant service providers.

Linked systems of health care: Models need to be developed to provide linked systems of health care year round between the communities in which the migrant lives. This is similar to the Air Bridge model existing between some NYC agencies and agencies in Puerto Rico.³⁹ Health care, access to health care, and HIV prevention services need to be provided in a way that works for a migrant population, as many of the immigrants are involved in migratory jobs (e.g., construction, fruit picking, landscaping).

OVERARCHING ISSUES:

Diversity within immigrant populations: The diversity and complexity within immigrant populations in New York City has grown over the last four years. There are many subgroups of immigrants, each with their own culture, social norms and language. For example, within the Asian and Pacific Islanders (A&PIs) community, 78% of those residing in New York City were foreign born, coming from 20 countries comprising 49 ethnicities and 100 languages.⁴⁰ This growth requires even greater culture-specific competency and poses more challenges with outreach prevention and intervention.

³⁸ Health and Mental Health Issues: Immigrant Youth and Families in New York. Report #2 (Winter 2001). New American Youth Initiative, The Center for New York City Affairs, Milano Graduate School of Management and Urban Policy, New School University.

³⁹ For additional information about this model of care, please visit their website at www.airbridgenetwork.com

⁴⁰ Statement of Need (August 2004). Asian & Pacific Islander Coalition on HIV & AIDS.

Attention needs to be paid to subgroups within the specific immigrant population. For example, although A&PI as a group does not show high rates of seroprevalence, there are subgroups within this community that show higher rates of HIV and AIDS.

Underreporting of transmission risk and the impact of HIV and AIDS on immigrant communities, especially the undocumented: Transmission risk for immigrants may be underreported. APICHA noted that among API's a large percent are classified as Under Investigation/Other for transmission category (39% of HIV cases and 29% of AIDS cases). They report:

According to epidemiologists and APICHA's empirical data gathered from clients and case managers, providers often fail to elicit information when patients have difficulty communicating their concerns to healthcare providers and when providers lack the skill to draw out culturally sensitive information from the clients.⁴¹

As the Bedford Stuyvesant/Crown Heights HIV Care Network reported, "Further epidemiological and needs assessment study of the impact of HIV and AIDS on the immigrant community in BSCH is implicated. Multiple focus groups conducted with translators are necessary to gather information that has not been documented by the City or the State."⁴²

Economic survival: There is a real issue of economic survival and poverty for those who don't have the ability to work legally, which lends itself to greater risk. Undocumented immigrants may become involved with prostitution, sex for survival, or drug carriers in order to support their children, because they do not have other avenues for work.

HIV training for immigrant service providers: There is a need for more quality and intensive HIV/AIDS training for immigrant providers. Training must take place on an ongoing basis in order to keep abreast of new policies, procedures, and laws, particularly those that pertain to immigrants. They must also address the role of religion in the gender and sexuality identity, attitudes about HIV and AIDS, and male/female roles.

HIV-focused models do not work. Models that do not work are those that are prominent in their display of HIV, and those that tackle HIV in isolation but do not address basic needs or deal with the structural barriers to care that immigrants face (e.g., fear of deportation, lack of identification card, etc.)

⁴¹ Ibid.

⁴² Bedford Stuyvesant Crown Heights HIV Care Network, 2000 Service Delivery Plan Update.

MODELS FOR EFFECTIVE HIV PREVENTION FOR IMMIGRANTS IN NEW YORK CITY

Key informants reported that models based on trust and safety are the most effective in terms of reaching immigrants, due to great fear about deportation and stigma.

Peer driven models. Immigrants are fearful of even going to the Department of Health Anonymous Test Sites as they have heard (whether correct or incorrect) that Immigration and Naturalization Services (INS) will be contacted immediately. If peers deliver the message, there is less fear. The peer should disseminate accurate information about safe places to test, and safe places to get services.

Church based models. Providing HIV prevention and care forums through the churches is an effective model because the faith-based organizations already engender a sense of trust and provide a mechanism of support for immigrants. Nevertheless, there is a need to provide HIV prevention within the context of church and cultural values.

Radio and television. An additional model for successful engagement is to reach people through the underground radio stations, local cables and networks that are geared to specific immigrant groups, such as the Caribbean populations.

Flexibility is key. The models that work best are those that are highly individualized and that offer flexibility around program eligibility. Some of the funding sources prevent agencies from serving undocumented immigrants. Resources are needed to meet the basic needs first, such as food and housing.

Language and cultural competency. There is a need for language and cultural competency, and a flexibility that is often difficult under rigidly set funding restrictions. The models that work best are those that are linguistically and culturally matching. These models should be located where the immigrants live, or provide outreach to their community to bring immigrants into the service delivery system. Having someone who speaks your language provide your HIV test creates a greater sense of comfort. The need for translators can create problems, especially if the patient has a family member or friend translating for them, which violates that person's privacy. Non-staff translators can create an additional layer of confidentiality while also reducing the level of contact and trust between the practitioner and the client. Materials need to be written in the person's native language, not just English.

Comprehensive health care model. Agencies must address the holistic health care concerns of the undocumented community. Undocumented immigrants may not have accessed health care in their home country, and now do not have insurance here to receive health care. If they have not had health care in their home country, their interaction with health care in this country may be the first time that HIV prevention has been addressed.

For HIV-positive immigrants, their HIV medical care may be their point of entry into health care services. Sessions might take longer, but general health care needs to be addressed first, rather than just focused on HIV. People will come to speak with the health care professional about other issues, such as diabetes, prostate problems, TB, etc. For women, breast and cervical cancer issues need to be addressed. One agency reported that most of the immigrant women they serve have never had a pap smear. General health care, health care advocacy and HIV care need to be integrated and comprehensive.

Immigrant agency based model. Providing HIV prevention services through an immigrant agency is an effective way of reaching immigrants where they are. By providing HIV prevention services in a place already known for providing immigrant services, it establishes credibility. HIV prevention education can be discussed within the context of surviving in New York, and in a way that reduces stigma. Sessions on health care, rather than an HIV-specific workshop, will best reach the immigrants by addressing their broader needs and concerns. An agency that is “immigrant friendly” is key.

RECOMMENDATIONS

Based on the above findings, the following recommendations have been developed to support the availability, accessibility and effectiveness of HIV prevention services for immigrants in New York City.

Issue 1: There is a need for reduced stigma and increased trust between immigrants and service providers and staff. Fear, stigma, social isolation and denial are particularly strong barriers to HIV counseling and testing.

Recommendation 1: Ensuring that agencies are “immigrant friendly” will help increase trust, and potentially reduce social isolation. Stigma can be addressed through the types of materials displayed throughout the agency. Agencies may use the document developed by the Latino Commission on AIDS entitled, “25 Things You Can Do To Make Your Organization Immigrant-Friendly” as a guide (see Appendix C). Hiring staff who reflect the community and using peer educators are excellent service models which will help to reduce stigma and social isolation, and engender trust.

Issue 2: There is a need for HIV prevention education to be culturally appropriate.

Recommendation 2: HIV prevention messages need to be reviewed by members from the immigrant group prior to their implementation. The venue in which they are provided must also be culturally appropriate. Non-traditional settings should be targeted, such as health fairs, food pantries, migrant worker stops, soccer games, restaurants and social clubs and activities. In addition, conducting large scale media campaigns through radio and television stations specific to the immigrant group, and the use of bus stop and subway promotions, can increase community awareness. Traditional cultural mediums such as art, music, and dance should also be used to deliver HIV prevention messages.

Issue 3: There is a need for more effective outreach models and messages.

Recommendation 3: Outreach models must be targeted to specific population, e.g., immigrant women. HIV prevention assessment and education services need to be integrated into other basic services to be effective. They should be included in services provided by non-HIV specific immigrant service agencies, medical sites including STD diagnosis and treatment centers, medical and substance use service sites. Incorporating HIV prevention throughout the services that immigrants are already accessing will reduce barriers and remove the stigma of attending services at an “HIV agency.” Labor intensive forms of outreach include door-to-door street outreach in social clubs, housing projects, factories and other workplaces, concerts, parties and boat cruises.

Issue 4: There is a need for improved language availability in person's native language, especially considering the dramatic increase in immigrant diversity in NYC over the past few years.

Recommendation 4: Availability of providers and staff who speak the client's native language is preferable. Funding support is necessary to support the agency in hiring translators when staff is not available. Hiring professional translators and interpreters will insure accuracy and most importantly, help maintain patient confidentiality by not using the patient's family members or friends as translators. Linguistic appropriateness includes understanding the cultural nuances unique to the population.

Issue 5: There is a need for increased legal services. The list of legal providers in New York City is short and the need has increased. Immigrants often need help addressing legal issues before they can comfortably access care including HIV counseling and testing.

Recommendation 5: Create and develop free professional legal services within immigrant agencies.

Issue 6: There is a need for improved housing opportunities, as lack of decent housing can leave immigrants living in non-supportive situations and reducing their locus of control and ability to enact new behaviors, or seek prevention or care services for fear of being "found out."

Recommendation 6: Development of housing options for all immigrants, regardless of HIV status or immigrant status will help improve the individual's prevention efforts.

Issue 7: There is a need for additional supportive services such as mental health services, food and nutrition, drug treatment and substance abuse services, ESL and literacy services, domestic violence programs, and emergency assistance.

Recommendation 7: Advocacy for additional services available to immigrants, whether documented or undocumented, is necessary. This needs to include identification of available services, and development and/or expansion of services where needed. The development of *HIV Prevention Services for Immigrants: A Referral Resource Directory of New York City Agencies* is a first step in this direction. This needs to be distributed and updated periodically, so that it can become a useful tool for the immigrant community.

Issue 8: There is a need for community-based immigrant organizations and HIV providers to work more closely together to reach those at highest risk.

Recommendation 8: HIV service providers and immigrant service providers need to be supported in working together collaboratively. This includes cross-collaborations between local churches, medical providers, legal service providers and community-based organizations. Developing and supporting models where cross collaboration assists both agencies can be a first step. One example would be to have the immigrant serving organization serve as the cultural educator for the HIV prevention service agency staff.

Issue 9: There is a need for providers to be knowledgeable about current legal issues facing immigrants, especially in light of changing policies and increased fear of deportation after 9/11.

Recommendation 9: Training must be provided to staff at HIV prevention programs and agencies serving immigrants to keep staff up-to-date on current immigration issues. Training should be provided at least annually, preferably twice yearly, to keep up with staff turnover, ongoing changes in immigration law and issues.

Issue 10: There is a need for improved staffing at agencies serving immigrants.

Recommendation 10: Immigrant staff at agencies serving immigrants is key. At least 50% immigrant staff is preferable. Staffing support must include ongoing (at least annual) training on cultural values and norms, HIV prevention education, male/female roles, gender and sex roles, unique challenges facing immigrant women, discrimination, homophobia, religion, attitudes about HIV and AIDS, alcohol and drug use, and sensitivity to fear of deportation. All of the training topics must be discussed within a cultural context. Staff retention must also be addressed. Resource support to improve staff salaries to competitive levels should help improve retention.

Issue 11: There is a need to improve access to both anonymous and confidential HIV counseling and testing services. This is a key point of access, and needs to be an integrated part of HIV prevention and care.

Recommendation 11: Information about availability of HIV counseling and testing services must become widely available throughout the communities. Agency staff must be well versed in immigration issues as they relate to HIV testing, to help clients determine their best testing option. Peer education can be very valuable, as peers can help clients understand the usefulness of testing within their cultural context, and can help dispel fear and stigma more effectively than non-peers.

Issue 12: There is a need to develop early intervention services for immigrants.

Recommendation 12: Immigrants often enter care late in the course of their HIV infection due to fear and stigma. Innovative models of care, using peers as case finders and navigators, should be developed, implemented and evaluated to determine their effectiveness in bringing HIV-positive immigrants into care earlier in the course of their disease. Awareness about Child Health Plus, Medicaid and other health insurance options needs to be expanded. Specifically, information must be clear that enrollment will not endanger residency status or lead to deportation or future harm. The NYS Access to Health Care model may be addressing this issue, and can be explored.

Issue 13: There is a need to increase financial support for community-based immigrant provider organizations to develop agency stability and ability to integrate additional services to meet current client needs.

Recommendation 13: Designate funds for community-based immigrant provider organizations to receive technical assistance for improving infrastructure, developing or refocusing HIV prevention efforts, and encouraging coordinated models of HIV prevention and care. Increase resources for peer education programs; train-the-trainers programs; research and evaluation; and community-based interventions.

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Latino Commission on AIDS

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NYS Black Gay Network

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APICHA

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Harlem Directors Group

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ECQ Intern

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Project Hospitality

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HIV Prevention Service Needs for Immigrants in New York City: Needs Assessment and Gaps Analysis Report was prepared for the New York City Department of Health and Mental Hygiene by the ECQ Group, Inc. through the work of Elizabeth Levine, MA, MPH, Executive Director, ECQ Group, Inc., Janet Goldberg, MPH, and Rosalie Sanchez, MA.

APPENDIX A

Survey Questionnaire for Organizations

Providing HIV Prevention Services to Immigrants

Thank you for helping us create a comprehensive directory of New York City-based HIV prevention services for immigrants.

Contact Person

Name of Person Filling Out the Survey: _____

Title: _____

Telephone: () _____ E-mail: _____

Agency Information

Agency Name: _____

Address: _____

Telephone: () _____ Fax: () _____

Website: _____ E-mail: _____

Nearest subway line and station? _____

What is the agency and/or HIV prevention program mission and vision? (Pls. include both if available. Attachments may be enclosed.)

Mission: _____

Vision: _____

Program Description of HIV prevention services:

1. What types of HIV prevention services does the agency provide to immigrants?

- Needle Exchange
 - Primary Prevention (prevention for HIV negative individuals)
 - Secondary Prevention (prevention for HIV positive ind.)
 - Partner notification assistance
 - Distribution of risk-reduction materials
 - (Pls. specify:
 - condoms
 - sterile syringes/injection equipment
 - bleach kits
 - Other: (Pls. specify: _____)
 - Legal services
 - Housing assistance
 - Food and Nutrition program
 - Substance Abuse/Drug treatment program
 - STD screening and treatment
 - Peer outreach and education program
 - Peer training program
 - Information and counseling hotline
 - Other services not yet mentioned
- (Pls. specify: _____)

2. Does the agency provide primary and secondary HIV prevention services to immigrants?

- Primary (to HIV⁻/status unknown) yes no
- Secondary (to HIV⁺ individuals) yes no

3. Who are the target populations of the agency's HIV prevention program (√ category)?
 What percentage of the total clients does each group represent? (√ appropriate box)

	0-20%	21-40%	41-60%	61-80%	81-100%
<input type="checkbox"/> Men					
<input type="checkbox"/> Women					
<input type="checkbox"/> Seniors					
<input type="checkbox"/> Youth					
<input type="checkbox"/> Children					
<input type="checkbox"/> LGBT					
<input type="checkbox"/> Other (Please specify)					

4. What is the racial/ethnic breakdown of the immigrant client population who receive HIV prevention services (√ category)?

What percentage of the total clients does each group represent? (√ appropriate box)

	0-20%	21-40%	41-60%	61-80%	81-100%
<input type="checkbox"/> Caucasian (which nationalities)					
<input type="checkbox"/> African (which nationalities)					
<input type="checkbox"/> Caribbean (which nationalities)					
<input type="checkbox"/> Asian/Pacific Islander (which nationalities)					
<input type="checkbox"/> Latino (which nationalities)					
<input type="checkbox"/> Native Hawaiian/Pacific Islander (which nationalities)					
<input type="checkbox"/> Other (Please specify)					

5. What are the countries of origin of the clients' served by the agency's HIV prevention program? (Please name top four.)

	Country of Origin		Country of Origin
1		3	
2		4	

6. What percentage of your staff are immigrants (0-20%, 21-40%, 41-60%, 61-80%, 81-100%)? _____

7. What languages, other than English, does your HIV prevention staff speak?

8. Does the agency have the ability to serve the undocumented? Yes No

9. Does the agency have eligibility requirements or restrictions for the HIV prevention program? (i.e. citizenship status, sobriety requirements, etc.)

10. Does your agency provide free or a sliding scale fee for HIV prevention services? Yes No

11. What document(s) does the client need to bring to the first visit? (i.e. photo ID, etc.)

12. Does the agency have more than one HIV prevention service site? Yes No

If yes, please provide site contact information.

Program Name	Site Address	Telephone	Nearest Subway
		() -	
		() -	
		() -	
		() -	

13. What are the agency's hours of operation and days of the week that it provides HIV prevention services for immigrants? If you have more than one site, please attach the hours for each on an additional page.

Monday	Tuesday	Wednesday	Thursday	Friday

14. In which borough(s) does the agency provide HIV prevention services for immigrants?

- Bronx
 Brooklyn
 Manhattan
 Queens
 Staten Island

15. Are there other HIV prevention service agencies/programs that you recommend we contact for possible inclusion in this directory?

Agency/Program Name	Site Address	Telephone	Contact Person
		() -	
		() -	
		() -	
		() -	

Thank you!

We welcome your comments and suggestions.

Please send completed questionnaire via mail, e-mail or fax to:

ECQ Group
 589 Eighth Avenue, 6th Floor
 New York, NY 10018
 Tel 212-244-0483
 Fax 212-244-1878
 E-mail chmartin@sc1881.org

APPENDIX B

Foundations that Fund Immigrant Proposals

The Abelard Foundation, Inc.
c/o White & Case
1155 Ave. of the Americas
New York, NY 10036

Ben & Jerry's Foundation, Inc.
30 Community Dr.
South Burlington, VT 05403
Telephone: (802) 846-1500
Contact: Debby Kessler, Admin. Asst.
www.benjerry.com/foundation/index.html

The Baron de Hirsch Fund
130 E. 59th St., 6th Fl.
New York, NY 10022
Telephone: (212) 836-1798
Contact: Lauren Katzowitz, Managing Dir.

The Discount Foundation
409 Crater Ct.
Henderson, NV 89014-4011
Telephone: (702) 547-6319
Contact: Susan Chinn, Exec. Dir.
FAX: (702) 547-6398
E-mail: Susanchinn@lvcm.com

The Ford Foundation
320 E. 43rd St.
New York, NY 10017
Telephone: (212) 573-5000
Contact: Barron M. Tenny, Secy.
www.fordfound.org

Gannett Foundation, Inc.
(Formerly Gannett Communities Fund/Gannett Co., Inc.)
1100 Wilson Blvd., 30th Fl.
Arlington, VA 22234
Contact: Irma Simpson, Mgr.
FAX: (703) 558-3819
E-mail: isimpson@gcil.gannett.com
www.gannettfoundation.org/

The Harburg Foundation, Inc.
225 Lafayette St., Rm. 813
New York, NY 10012
Telephone: (212) 343-9668
Contact: Nick Markovich, Exec. Admin.
FAX: (212) 343-9453
E-mail: harburgfndtn@mindspring.com

New York Foundation
350 5th Ave., No. 2901
New York, NY 10118
Telephone: (212) 594-8009
Contact: Madeline Lee, Exec. Dir.
www.nyf.org

The New York Women's Foundation
34 West 22nd Street
New York, NY 10010
Telephone: (212) 414-4342
www.nywf.org

Orisha Foundation, Inc.
220 5th Ave., Ste. 600
New York, NY 10001-7708
Telephone: (212) 532-6661
Contact: William Waterman, Jr., Pres.

Public Welfare Foundation, Inc.
2600 Virginia Ave., N.W., Ste. 505
Washington, DC 20037-1977
Telephone: (202) 965-1800
Contact: Review Comm.
E-mail: general@publicwelfare.org
www.publicwelfare.org

Shaler Adams Foundation
Presidio Bldg1016, Lincoln Blvd/Torney Ave
P.O. Box 29274
San Francisco, CA 94129-0274
Telephone: (415) 561-6570
Contact: Margaret K. Schink, Exec. Dir.
FAX: (415) 561-6491
E-mail: shaler@igc.apc.org

Union Square Awards
Fund for the City of New York
121 Avenue of the Americas, 6th Floor
New York, NY 10013
www.fcny.org/unionsquare

Unity Avenue Foundation
c/o Scenic River, Inc.
P.O. Box 204
Bayport, MN 55003
Telephone: (651) 439-1157
Contact: Sarah J. Andersen, Grant Consultant
FAX: (651) 439-9480

APPENDIX C

25 THINGS YOU CAN DO TO MAKE YOUR ORGANIZATION IMMIGRANT – FRIENDLY⁴³

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:

X **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

⁴³ Reprinted from Latino Commission on AIDS, *HIV Prevention Services for Immigrant and Migrant Communities*. December 2001.

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.

- X **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.

- X **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.

- X **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:

- X **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?”
- X **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.
- X **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.
- X **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.

APPENDIX D

Glossary of New York City Prevention Planning Group Acronyms

Acronym	Full name
ADAP	AIDS Drug Assistance Program
AED	Academy for Education Development
AI	AIDS Institute
AIDS	Acquired Immunodeficiency Syndrome
AOD	Alcohol and Other Drugs
API / MSM	Asian Pacific Islanders / Men who have Sex with Men
APICHA	Asian Pacific Islanders Coalition on HIV/AIDS
ASAP	As Soon As Possible
BOE	Board of Education
CBO	Community Based Organization
CC	PPG Coordinating Committee
CD	Compact Disk
CDC	Centers for Disease Control and Prevention
CJ	Criminal Justice
COC	Communities of Color
C-PLOT	National CDC Community Planning Leadership Training Group
CPLS	Community Planning Leadership Summit
CTL	City Tax Levy
DL	Down-Low
DOH	Department of Health
EC	Executive Committee
ED	Executive Director
EPI	Epidemiology
ESAP	Expanded Syringe Access Program
FEDS	Federal Government
GMHC	Gay Men's Health Crisis
HIV	Human Immunodeficiency Virus
HRSA	Health Resources and Services Administration
HTI	HIV Training Institute
IDUHA	Intervenious Drug Users Health Alliance
IBSE	Interventions, Behavioral Sciences & Evaluation Committee
IDU	Injection Drug Use
MOCA	Men of Color AIDS Prevention
MHRA	Medical & Health Research Association of NYC, Inc
MSM	Men who have Sex with Men
MSW	Men who have Sex with Women
MTFA	Minority Task Force on AIDS
NAACP	National Association for the Advancement of Colored People
NASTAD	National Association of State & Territorial AIDS Directors
NIR	Not Identified Risk
NDRI	National Development and Research Institute
NMAC	National Minority AIDS Council
Non-Gay Identified MSM	Non-Gay Identified Men who have Sex with Men
Non-IDU	Non Injecting Drug Users
NRR	Not Reported Risk

Acronym	Full name
NYCCOCHA	New York City Communities of Color HIV/AIDS Coalition
NYHRE	New York Harm Reduction Educators
NYLINK/SUNY OCLC	New York Link /State University of New York library database
OGLH	Office of Gay & Lesbian Health
PC	HIV Planning Council
PEG	Program to Eliminate the Gap (Budget)
PEMS	HIV Program Evaluation and Monitoring System
PERL	Policy & External Relations Committee of NYC PPG
PCRS	HIV Partner Counseling and Referral Services
PHP	Positive Health Project
PPG	Prevention Planning Group
PPU	Prevention Planning Unit, NYC Dept of Health & Mental Hygiene
PSA	Public Service Announcement
PTI	Peer Training Institute
PWA/PWHIV	Persons living With AIDS / Persons living With HIV
RAD	Resource Allocation Database
RFP	Request For Proposal
RMC	Rules and Membership Committee
RTM	Risk Targeting Model
SAMHSA	Substance Abuse and Mental Health Services Administration
SIECUS	Sex Information and Education Council of the US
SEP	Syringe Exchange Program
SPSS	Statistical Package for Social Sciences
STD	Sexually Transmitted Disease
SUWG	Substance Users Workgroup
UCHAPS	Urban Coalition for HIV/AIDS Prevention Services
USCA	United States Conference on AIDS
WCWG	Women and Children Workgroup
WG	Workgroup
YMS	Young Men's Survey study
YMSM	Young Men who have Sex with Men

APPENDIX E

LITERATURE REVIEW

AIDS Center for Queens County (July 2004). *Statement of Need Document*.

Alonso (Spring 2001). *Immigration and HIV: The Undercurrent of Change*. Presentation, Immigrants and HIV/AIDS Conference: Access to Care. Elmhurst Hospital, Queens, New York.

Asian & Pacific Islander Coalition on HIV & AIDS (October 2001). *East Coast Asian & Pacific Islander Population and HIV/AIDS Surveillance Profile*.

Asian & Pacific Islander Coalition on HIV & AIDS, The Northern Queens Health Coalition, New York Hospital of Queens, and The Queens Health Network: A Joint Report (November 15th, 2001). *Status of Immigrants and HIV/AIDS in Queens*.

Asian & Pacific Islander Coalition on HIV & AIDS (August 2004). *Statement of Need*.

Bedford Stuyvesant/Crown Heights Community Coalition on Research and Planning. Interfaith Medical Center, Lead Agency.

Bedford Stuyvesant/Crown Heights HIV Care Network (2000). *2000 Service Delivery Plan Update*.

Brookings Institution Center on Urban and Metropolitan Policy (2003). *New York in Focus: A Profile from Census 2000*.

Brooklyn AIDS Task Force, Community Resource Department (2001). *Queens AIDS Fact Sheet*. Brooklyn, New York.

Castle, M.A., Sauvage-Mar, C., Sanchez, R., Majithia, S., Ports, S.T. *HIV prevention among Asian women immigrants in New York City*. Sexual Health Exchange, 2001-2.

Census Data. 2000.

Center for Women in Government & Civil Society & Family Planning Advocates of New York State (December 2002). *Working Together to Increase Immigrant Women's Access to Reproductive Health Care. Report on Statewide Roundtable*.

Chou, M-C, et al. (1999). *HIV Knowledge, Condom Use Self -Efficacy, and Intention to Practice Safer Sex among Asians in New York City* APICHA. Abstract 432, 1999 National HIV Prevention Conference.

Community Health Status Report Queens County, New York (July 2001). Health Resources and Services Administration.

Cordero-Guzman, Ph.D., (May 2000). *What Do Immigrant Service Providers Say About the Impact of Recent Changes in Immigration and Welfare Laws*, Migration World Magazine. v28,i4, p20.

Discipleship Outreach Ministries, Inc. (June 2004). *Statement of Need Document*.

Family Planning Council Training 3, The DHHS Region III Family Planning Training Center (2002). *Cultural Competence and Reproductive Health. A Guide to Services for Immigrants and Refugees*.

Forlenza, SW, et al. (1999). *AIDS in Immigrants in New York City*. New York City Department of Health. Abstract 206, 1999 National HIV Prevention Conference.

Health Resources and Services Administration HIV/AIDS Bureau (October 2000). *Report #6: Delivering HIV Services to Vulnerable Populations: What Have We Learned?*

Health Resources and Services Administration. Special Projects of National Significance (October 2003). *Caribbean Initiative: HIV prevention for HIV+ Caribbeans (Trinidad/Tobago, Jamaica and Haiti)*.

Health Resources and Services Administration HIV/AIDS Bureau (January 29-February 3, 2004). *Report: Crosscutting Issues, Racial and Ethnic Minority Populations, Access to HIV/AIDS Care Issues, Community Consultations*.

Health Resources and Services Administration HIV/AIDS Bureau (February 2, 2004). *Report: Asian and Pacific Islander Community Consultation, Access to HIV/AIDS Care Issues*.

Health Systems Agency of New York City, Inc. (January 1995.) *Interim HIV/AIDS Strategic Plan for the City of New York: HIV-Infected Recent Immigrants and the Undocumented*.

Henry. J. Kaiser Family Foundation (October 2003). *The Healthcare Experiences of Women with HIV/AIDS: Insights from Focus Groups*. Prepared by Lake Snell Perry & Associates, Inc.

HIV Health and Human Services Planning Council of New York (January 2002). *Report and Recommendations of the Immigration Planning Group*.

HIV Health and Human Services Planning Council of New York (September 2002). *New York Eligible Metropolitan Area Comprehensive Strategic Plan for HIV/AIDS Services, 2002-2005*. Prepared by McClain and Associates, Inc.

HIV Health and Human Services Planning Council of New York City (Draft, June 2004). *New York Eligible Metropolitan Area Needs Assessment Update, 2004. Update to the 2002 Initial Needs assessment New York HIV Health and Human Services Planning Council*. Prepared by McClain and Associates, Inc.

Immigration, Ethnicity and Acculturation in Culturally Anchored HIV Prevention for Asian/pacific Islander Populations: A Qualitative Study. Abstract 587, 1999 National HIV Prevention Conference

Kaiser Family Foundation (November 2001). *Latinos and HIV/AIDS*.

Krain, A (2001). *Medical Issues in HIV Positive Immigrants*. Mount Sinai Medical Center HIV/AIDS and Immigrants Health Conference. Presentation, May 9, 2001.

Latino Commission on AIDS (December 2001). *HIV Prevention Services for Immigrant and Migrant Communities*.

Latino Health Advocates Founders Summer Working Group. *Good Intentions are not Enough! Latino Health Disparities and Barriers to Health Care Access*. Draft Report.

Lo, K.C. (December 2003). *HIV Prevention Among NYC Asian Immigrants: New York Academy of Medicine Study Focuses on Community Institutions*. *Body Positive*, Vol. XVI, No. 5.

Mayor's Office of Immigrant Affairs and Language Services, New York City. *Directory of Services to Immigrants: A Guide to Community-Based Organizations in New York City*.

Memorial Sloan-Kettering Cancer Center, Department of Psychiatry & Behavioral Sciences (October 2000). *VOICES: An Assessment of Needs Among Asian and Pacific Islander Undocumented Non-Citizens Living with HIV Disease in New York City*. Submitted to the Mayor's Office of AIDS Policy Coordinator & and the HIV Health and Human Services Planning Council. New York, New York.

New American Youth Initiative, The Center for New York City Affairs, Milano Graduate School of Management and Urban Policy, New School University (Autumn 2000). *Immigrant Girls: Struggling with Cultural Traditions. A Working Group Report*. Report #1.

New American Youth Initiative, The Center for New York City Affairs, Milano Graduate School of Management and Urban Policy, New School University (Winter 2001). *Health and Mental Health Issues: Immigrant Youth and Families in New York*. Report #2.

New York City Department of City Planning. *The Newest New Yorkers: 1990-1994 Executive Summary*.

New York City Department of Planning (September 1999). *The Newest New Yorkers, 1995-1996: An update of immigration to NYC in the mid '90s*.

New York City Department of Health. *New York City HIV Prevention Plan 2000*, Volume I.

New York City Department of Health and Mental Hygiene (2004). *Health Disparities in New York City*.

New York City Department of Health and Mental Hygiene (February 2004). *New York City Ryan White Title I Service Directory*. Prepared by HIV Care Services, A Project of MHRA, Inc.

New York City Health and Hospitals Corporation Presentation. *The Changing Picture of HIV/AIDS Care in the United States*. United Nations Special Session on AIDS,

New York City HIV Health and Human Services Planning Council (August 1996). *Consolidated Planning Tool*.

New York City HIV Health and Human Services Planning Council. Social Services Workgroup, Immigration Planning Workgroup. *Report and Recommendations from 1/22/02*.

New York City Office of the Mayor/AIDS Policy Coordination (September 2002). *New York EMA Comprehensive Strategic Plan for HIV/AIDS Services, 2002-2005*. Prepared by McClain and Associates, Inc.

New York City Office of the Mayor/AIDS Policy Coordination, New York HIV Health and Human Services Planning Council 2004 (July 2004). *Update to the 2002 Needs Assessment*. Prepared by McClain and Associates, Inc.

New York State AIDS Advisory Council (Winter 2000/2001). *Communities at Risk: HIV/AIDS in Communities of Color*.

NYS Department of Health AIDS Institute, Bureau of Special Populations, Bureau of HIV Ambulatory Care Services (November 2000). *Community Forums on HIV Prevention and Health Care for Women, Children, Families and Young People: Key Findings*.

NYS Department of Health AIDS Institute, Statewide AIDS Service Delivery Consortium (SASDC). *Summary of Issues and Barriers in Accessing Services and Service Needs/Priorities for the SASDC Six Special Populations*. Reported by the NYS Ryan White Title II HIV Care Network Coordinators.

NYS Regional Gaps Analysis, African Immigrant Discussion Group on HIV Prevention, Sub-Saharan Rescue League. Summary of Discussion Group, May 16, 2003. Staten Island, New York.

NYS Regional Gaps Analysis, Spanish-speaking Discussion Group on HIV Prevention, PROMESA. Summary of Discussion Group, June 18, 2003. Bronx, New York.

NYS Regional Gaps Analysis, Spanish-speaking Discussion Group on HIV Prevention, Hispanic AIDS Forum. Summary of Discussion Group, October 30, 2003. Queens, New York.

NYS Regional Gaps Analysis, Latino Spanish-speaking Discussion Group on HIV Prevention, Latino Commission on AIDS and Alianza Dominicana. Summary of Discussion Group, October 30, 2003. New York, New York.

NYS Regional Gaps Analysis, Asian and Pacific Islanders Discussion Group on HIV Prevention. Asian and Pacific Islanders Coalition on HIV/AIDS. Summary of Discussion Group, November 10, 2003. New York, New York.

NYS Regional Gaps Analysis, Two Spanish-speaking Discussion Groups on HIV Prevention. Discipleship Outreach Ministries, Inc. Summary of Discussion Group, November 6, 2003. Brooklyn, New York.

NYS Regional Gaps Analysis, Haitian Discussion Group on HIV Prevention. Haitian Centers Council. Summary of Discussion Group, November 5, 2003. Brooklyn, New York.

NYS Regional Gaps Analysis (August 2003). HIV Prevention Planning in the Bronx, Final Report. Bronx, New York.

NYS Regional Gaps Analysis (October 2003). HIV Prevention Planning in Brooklyn, Final Report. Brooklyn, New York.

NYS Regional Gaps Analysis (December 2003). HIV Prevention Planning in Manhattan, Final Report. New York, New York.

The United Way of New York City. *New Americans Need Help to Join Mainstream & Move Up Economic Ladder.*

The United Way of New York City. *Voices from the Field "Building Bridges and Removing Barriers: A Strategy to Promote the Self-Sufficiency of New York's Immigrant Communities.* p.8.

University of California at San Francisco, Center for AIDS Prevention Studies (April 1998). *What are Asian and Pacific Islander HIV Prevention Needs?* Asian and Pacific Islander American Health Forum, CAPS. Fact Sheet #33E. Prepared by I. Bau and P. DeCarlo,

Vera, T. (May 2000). *The NYC HIV/AIDS picture does not look promising for Latinos.* Committee on Latino Affairs. National Association of Social Workers, New York City Chapter.

Velez, P. L. and Novoa, R. *Immigration and HIV Infection,* Gay City News.

Resource Directories:

- Bedford Stuyvesant/Crown Heights Community Coalition on Research and Planning Resource Directory
- Bronx HIV Care Networks' Resource Directory of HIV/AIDS Community Services. Spring 2002.
- Community Coalition Project of Central Brooklyn Resource Guide. The Miracle Makers, Inc. Lead Agency.
- Directory of New York Area African Immigrant Associations, March 2003.
- Directory of Services to Immigrants: A Guide to Community-Based Organizations in New York City. New York City Mayor's Office of Immigrant Affairs and Language Services.
- New York Academy of Medicine Library, www.aidsnyc.org On-line directory of AIDS Service Providers.
- New York City HIV Prevention Program Service Directory. Summer 2004
- Queens HIV Care Network Service Delivery Plan 2002 Resource Directory
- Rainbo.org, African CBO Network in NY
- Resource Directory for South Asian Health and Human Services in New York and New Jersey. South Asian Health Project.
- Williamsburg Greenpoint Bushwick HIV Care Network Resource Directory 2004.