

Racism and HIV/AIDS among
African Americans; Dismantling
one Addresses the other

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P/M 55

ABSTRACT

Nationally, HIV/AIDS transmission rates are rising in African American communities, while decreasing in white, gay communities where the disease has been most devastating. Classism, homophobia, lack of cultural competency/sensitivity, distrust of health care providers, and racism are all social and cultural components which contribute to the spread of this pandemic. Racism has historically impacted the lives of African Americans in many different forms. Unfortunately, racism has also impacted the rate of HIV/AIDS transmission among African Americans. This project addresses the questions: Does personal, cultural, and institutional racism effect HIV/AIDS transmission among African Americans in Seattle-King County, and if so how? How does it effect HIV/AIDS education, prevention and outreach efforts in African American communities? How does it effect how African Americans receive education and prevention messages?

I answer these questions by defining personal, cultural and institutional racism, examining the historical context of disease maintenance by summarizing the Tuskegee Syphilis Study and making ties to African American's distrust of the health care system. In addition, this project explores the barriers to education and prevention, the development and implementation of culturally sensitive messages, and the ways in which funding allocations and multilevel support lay the groundwork for identifying effective prevention methods. Finally, there is a discussion that highlights the impact of these findings. Establishing how HIV/AIDS transmission is impacted by racism creates the foundation for developing anti-racist, multiculturally sensitive HIV/AIDS prevention programs, programs that are free of blame and aim to heighten accountability of African and European Americans' fight against HIV/AIDS.

ACKNOWLEDGMENTS

In Memory of Patrick G. Gossett
(November 1, 1955 - July 17, 1997)

Your strength, wisdom and character truly exemplified the stamina needed to confront life's challenges and appreciate life's gifts. I am honored that we were able to share a brief moment in time together.

Dedication

To the many African Americans unaware of HIV/AIDS and its devastating effect on our lives, change is soon to come.

Special Thanks

To Mrs. B. Lapsley-Ewing for your encouragement when I began to doubt myself and my abilities; Russell D. Campbell for your patience and love throughout this process. You made a difference!; Kayleen Oka for your camaraderie from beginning to end; Ronald Johnson (RJ) for the continuous laughs and reality checks; Donald Proby for your belief in me; People of Color of Against AIDS Network for the work that you do to educate so many people with so few resources; Meri Danquah for providing insight and sharing your story. This list, by no means, includes everyone but thank you to all who contributed.

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INTRODUCTION

The first reports of HIV/AIDS in the media categorized it as a white gay disease. People believed that European American gay men were the only group susceptible to getting the virus because the highest rates of HIV/AIDS infection were found within this population. That was the 1980's. Today, reports reflect a different story and paint a different picture. HIV/AIDS infection rates are rising in astonishing proportions among African Americans and Latinos, particularly among heterosexual women who are the partners of bisexual men; men who have sex with men but do not identify as being gay/bisexual; and intravenous drug users. Why are these populations hard hit by the disease, when European American gay men, who have lost thousands of lives due to AIDS-related deaths, have managed to stabilize their HIV/AIDS transmission rates? This question points to larger issues that have a direct correlation to the rising rates of HIV/AIDS transmission within African American communities.

As a Community-Based Service Liaison and African American Men's Group Facilitator/Trainer at the People of Color Against AIDS Network (POCAAN -- an AIDS service organization), I had the opportunity to work with African Americans in both care and prevention services. Clients living with HIV/AIDS often faced severe difficulty receiving services to sustain and maintain life. Simultaneously, prevention and education messages aimed at African American audiences by white agencies were not culturally relevant or appropriate. Therefore, the messages did not reach African Americans and this continues to be a treacherous cycle. Since HIV/AIDS prevention messages are targeted toward, but not reaching, African American communities, HIV/AIDS transmission rates continue to rise.

This paper presents and addresses the questions: Does personal, cultural, and institutional racism effect HIV/AIDS transmission among African Americans in Seattle-King County, and if so how? How does it effect HIV/AIDS education, prevention and outreach efforts in African American communities? How does it effect how African Americans receive education and prevention messages? I explore these topics by dividing the paper into seven chapters.

Chapter 1 establishes the foundation for defining and exploring the various levels of racism. Following the definitions are the identification of the roles European and African Americans play in perpetuating racist thoughts and practices. I will then discuss the levels of racism that perpetuate this thinking. As a point of clarification, the term European American will be used in reference to whites/caucasian people who reside in the United States whose culture of origin is Europe. Likewise, I will use the term African American to describe only people of African descent who reside in the United States. I make this distinction because people who appear to be African American may be from the Caribbean Islands or Africa. Regardless of their native cultures upon arrival, in the United States, they likely will be seen and treated as African Americans.

Chapter 2 will provide a historical perspective of disease maintenance among African Americans. This examination recaps the Tuskegee Syphilis Study, discusses its historical impact within African American communities, and addresses the effects it has on HIV/AIDS transmission.

Education and prevention are the subjects of Chapter 3. The barriers to HIV/AIDS education and prevention in African American communities has a direct impact on the high rates of transmission. Exploring the psycho-political/social and financial impact of the dissemination of messages to African Americans provides an overview that can demonstrate the links between racism, lack of cultural sensitivity, an unwillingness to change old paradigms of funding distribution, and increased rates of HIV/AIDS transmission.

Chapter 4 addresses research conducted in Seattle-King County among a cross section of African Americans designed to assess their experiences of seeing, hearing and receiving HIV/AIDS messages. The interview-based research questions evaluate knowledge of HIV/AIDS prevention in the target population. This research identifies patterns which provide insight into the thesis questions.

Chapter 5, entitled "Effective Methods," focuses on intercultural methods that can be adapted by agency personnel to reach African Americans. Since HIV/AIDS transmission rates are rising in African American communities, agencies will have to address this pandemic differently than they have in the past. This chapter will recommend effective methods for doing so. Street level outreach, community-based education, cultural relativity, and organizational practices will be highlighted.

Chapter 6 takes into account the impact of my findings and offers recommendations. In essence, what does all of this mean? This chapter will discuss the impact of my findings

and offer recommendations to help decrease escalating rates of HIV/AIDS transmission among African Americans.

The Conclusion offers questions for future exploration of these topics.

Chapter I

RACISM

The Oxford Dictionary defines racism as the belief in the superiority of a particular group with prejudices based on this belief (1995). Racism can be conscious or unconscious, and is expressed in actions, attitudes, behaviors and even in the language we use to understand and describe our world. It is initiated by individuals, groups or institutions that treat certain human beings unjustly because of skin color. It is deeply woven into the fabric of United States culture (Hayes & Colin, 1994). It is reflected in individual actions and in our institutions.

Racism in the United States reflects belief systems that explicitly or implicitly portray African Americans, Native Americans, Latino Americans, and Asian/Pacific Islanders (People of Color) as deficient, thus justifying discriminatory treatment. This belief system or race ideology serves as a means of social control and maintains the power of the dominant group. Beliefs surrounding racial groups are shaped by historical, social and political factors. Many of these beliefs reflect stereotypes that perpetuate inaccurate generalizations about racial groups' characteristics (1994). These stereotypes are reflected in current widespread notions, such as African Americans are more violent and less intelligent than European Americans. These beliefs, accompanied by behaviors, serve to oppress People of Color.

Oppression is the systemic social phenomenon based on the differences between social groups that involve ideological domination, institutional control and the dissemination of

the dominant group's ideology and culture on targeted groups. The dominant group has the societal power to define and enact reality, determine what is "normal," "real," and "correct" and impose this ideology on the targeted group. Within this system, the targeted group's way of naming reality is eradicated, misrepresented or discounted by the dominant group (Hardiman and Jackson adapted from Paolo Friere, 1996). For example, the passion and high energy African Americans sometime use to communicate is often viewed by European Americans as hostile and/or angry. In reality, they are simply expressing and articulating thoughts in a culturally relevant manner. European Americans view this type of communication as negative and often attempt to stifle this communication style. In the workplace, European Americans use disciplinary actions against African American employees to discourage this. In schools, young African American children are taught to communicate the "right way." This means abandoning their cultural language patterns to adapt to mainstream, European American, speech patterns.

Gloria Yamato states that racism is pervasive to the point that we take many of its manifestations for granted, believing "that's life" (1994). She identifies four forms of racism that prevail today 1) aware/blatant racism 2) aware/covert racism 3) unaware/unintentional racism and 4) unaware/self-righteous racism. Aware/blatant racism metaphorically refers to the top of an iceberg that is above water. It is obvious and visible. These are, for example, acts carried out by European American supremacist groups or when derogatory ethnic labels are used to describe People of Color. These actions indicate that People of Color's skin pigmentation is not accepted or appreciated. Aware/covert racism refers to the incidents of racism whereby European Americans are aware that they hold racist thoughts yet keep them self-contained. My personal experience of aware/covert

racism occurred in a Boston department store while I was in graduate school. A security guard followed me throughout a store because of his stereotype of what I -- a 6'6", African American male -- represented to him. Another example can be drawn from my car shopping experience. I visited an auto dealership to test drive a car. The salesperson photocopied my driver's license and insurance card before allowing me to test-drive a car. Meanwhile, the European American couple next to me test-drove a car without ever showing their identification. "Unaware/unintentional racism drives usually tranquil white liberals wild when they are called on it, and confirms the suspicions of many People of Color who feel that white folks are just plain crazy" (Yamato, 1994). With the best of intentions, education and the greatest generosity of heart, European Americans, operating on the misinformation that they were given from day one, will behave in ways that are racist and will perpetuate racism by being "nice" (1994). As a case in point, when I was co-governor of my undergraduate senior class, I was asked to attend a board of trustees meeting to select honorary degree recipients. My charge was to represent my classmates' recommendations. After the meeting, a trustee approached me to say, "You are not like the other Blacks I have met on campus." I inquired as to what he meant. He mentioned that the manner in which I spoke and the way I carried myself, was not like that of the other African Americans. His effort to be "nice" and to see me differently than my African American schoolmates was actually a perpetuation of racist attitudes and beliefs. My speech and behavior could not be seen as typical, instead they were viewed as exceptions. The unaware/self-righteous racist assigns him/herself the title "good white," as opposed to a "bad white". They are often found setting agendas for People of Color and telling them what needs to be addressed instead of taking time to deal with other European Americans. Inevitably, this means People of Color are still left to deal with what the "good whites"

don't want to... racism (1994). I recently heard a European American male state that in order to increase the number of African American engineers in the workplace, African Americans need to make the pursuit of the sciences a cultural norm. He had no consideration for social issues confronting African Americans or the institutional barriers which hinder this group.

Both groups have beliefs and practice behaviors which prolong the existence of racism. European Americans practice internalized superiority and dominant group privilege. Internalized superiority refers to the assumed belief that European Americans are the best or better than People of Color. For example, of 777 participants in a 1986 Race and Politics survey, 22% believed that African Americans were more violent than whites and 6% believed that African Americans were born with less ability (Sniderman & Piazza, 1993). These beliefs assume that European Americans are less violent and have more ability. Dominant group privilege is the daily unearned advantage that is afforded to a group based on race. The fact that African American males are often stopped in automobiles for the sole reason of their skin pigmentation exemplifies this dominant group privilege. European Americans seldom, if ever, have this experience in the United States.

Targeted groups also perpetuate racism through internalized racism, resistance, fear and confusion. Internalized racism means that targeted group members accept the messages of the dominant group, i.e. European Americans may believe that African Americans are less intelligent than European Americans which African Americans then internalize. Resistance refers to the targeted group's inability to challenge the ideology of the dominant group. For example, European Americans may believe that African Americans are less

intelligent than European Americans and when African Americans do not challenge that belief they contribute in perpetuating racism. Confusion surrounding racism develops around who is right regarding a belief held about targeted groups by the dominant group. For example, an African American woman is told all of her life that African Americans are highly intelligent. Societal messages later reinforce a belief that African Americans are less intelligent than European Americans. She becomes confused about who to believe - the beliefs of the targeted or dominant group. Lastly, fear may prevent the targeted group member from speaking out or going against the beliefs of the dominant group. In such a case, the African American woman would say or do nothing to combat the belief that African Americans are less intelligent than European Americans due to fear of retribution.

The manifestations of racism can be observed on three levels: the individual, cultural and institutional. Individual racism refers to a person's assumptions about People of Color. These derive from messages European Americans receive in their early years and are often carried out in behaviors toward People of Color. The attitudes support the belief that People of Color are culturally and biologically inferior to European Americans. From these beliefs stem the notion that People of Color should be exploited or discriminated against (Lott & Mott, 1995).

Cultural racism is perpetuated in the images or messages prevalent in society. For example, People of Color on television, and in print are often represented with European features. Women with long, straight hair and light-skinned complexions are compared with European American women with tanned skin. The unspoken message is that tight curl patterns or dark skin complexions, characteristic of African Americans, are not acceptable.

United States. institutions perpetuate racist ideologies with policies and procedures that give privilege to European Americans. This belief system defines a group by their racial identity and oppresses, controls and exploits them because of presumed cultural or biological characteristics (Andersen & Collins, 1995). Racism is institutional, or systemic, at the judicial, legislative, or executive level where the term "system" is applied. The judicial system is one such example. In a country where African Americans represent 12 - 13 % of the population, they have the highest number of prison inmates. This suggests an imbalance in the number of arrests, types of legal representation and sentencing of African Americans.

Racism is an integral part of US society. It can be both conscious and unconscious. Members of the dominant group and the targeted groups, play a significant role in the existence of racism. Personal/individual, cultural, and institutional levels of society perpetuate racism with manifestations that impact People of Color's lives. Simply put, racist attitudes impact behaviors toward and decision about People of Color.

To thoroughly discuss racism in relation to HIV/AIDS and African Americans, it is necessary to place this discussion in the context of the political climate of the 1980's, when HIV/AIDS was introduced to the country. The 1990's was a decade governed by conservative presidents Reagan and Bush. Their political stances on civil rights and race relations set a tone that paralleled those of the pre-Civil Rights Era.

The efforts of the civil rights movement in the 1960's pressured Congress into passing legislation banning discrimination in employment, voting, and housing. Under the leadership of President Reagan in the 1980's, federal civil rights enforcement agencies were destroyed or weakened. Until 1987, the U.S. President's budget included an appendix, called Special Analysis J, that reviewed the work of federal civil rights enforcement agencies. The allotment for civil rights enforcement was \$350 million which was merely a fraction of the President's trillion dollar budget. Ronald Reagan discontinued it (Feagin, 1997). President Bush also contributed in diluting civil rights enforcement. "Both Reagan and Bush appointed conservative justices to the Supreme Court, and [Supreme] Court decisions since the 1980's have restricted discrimination victims' ability to sue for redress (1997)."

The 1970's was largely a period of experimentation and implementation of variations on the theme of remedying prior racial discrimination by embracing affirmative efforts to increase the representation of members of historically disadvantaged groups. Yet, the conservatism of 1980's set a tone for racial intolerance against People of Color throughout the country. The results are evident today. In 1997, there were a number of constitutional challenges to affirmative action in employment, in higher education, in public contracting and procurement, and in a wide variety of related economic activities. European Americans challenged the constitutionality of affirmative action policies in an effort to protect their rights to racial equality.

This level of racism not only limits the livelihood of People of Color but also grants an added layer of privilege, entitlement, and superiority to European Americans, further oppressing People of Color.

These attitudes and behaviors are mirrored in the area of healthcare. Racism also exists in the healthcare system. Chapter 2 focuses on the Tuskegee Syphilis Study and addresses how racism in the healthcare system impacted decision-making in this study.

Chapter 2

YESTERDAY AND TODAY: THE TUSKEGEE SYPHILIS STUDY & HIV/AIDS

European Jews will never forget the deaths and atrocities associated with Hitler's domination of Europe. Just as ethnic cleansing and war will forever be in the minds of Bosnians as they rebuild their lives, African Americans remember the Tuskegee Syphilis Study. This study violated the trust that many African Americans had in the US government and in the healthcare system. In fact, the effects can still be seen in African American responses to healthcare, healthcare professionals and HIV/AIDS prevention today. Chapter 2 will explore the impact of the Tuskegee Syphilis Study on African Americans and HIV/AIDS prevention in present-day America.

The Tuskegee Syphilis Study was an experiment conducted by the United States Public Health Service (USPHS). In the late 1920's and early 1930's, syphilis "...accounted for one of the chief causes of draft rejection in the First World War, and this fact gave impetus to the establishment of the Control Program." As a result, the study was conducted (A Report of the Alabama Committee to the United States Commission on Civil Rights, 1973). "Out of two million registrants in the latter part of 1940 and part of 1941, serological tests produced 4.7% positive reactions to syphilis. The positive syphilis percentages among African American registrants rose to 20.1% which was more than five times the national average" (1973). This, in the minds of the Center for Disease Control (CDC), warranted a long-term study of untreated syphilis in a control program. "A 1946 article discussing the study defined it more specifically as a 'continuing attempt to follow the natural history of syphilis, uninfluenced by treatment, in adult male Negroes, with special attention to its

effects on the cardiovascular system" (Report of the Alabama Committee to the United States Commission on Civil Rights, 1973). Literature reviews indicate two primary reasons for the study: 1) to determine the effectiveness of treatment in preventing the spread of syphilis, and 2) to determine the effect that treatment had in preventing late and crippling manifestations resulting from syphilis (1973).

In addition to being an official program of the USPHS, the study had seven public and private supporters. The Milbank Memorial Fund provided capital to pay for subject's burial and autopsy expenses. Tuskegee Institute's John A. Andrew Memorial Hospital handled the administration of funds for the burials and autopsies. They also provided hospital facilities. "The Veterans Administration Hospital of Tuskegee made available the voluntary services of a doctor and its x-ray and EKG facilities. The Macon County Health Department provided local supervision of the program from its inception" (1973). The Alabama Health Department was involved by simply being aware of the study. The Macon County Medical Society was consulted and advised, and therefore became a participant. Lastly, the cooperation of Tuskegee's established morticians was essential for the success of the study. The Commission on Civil Rights reported that all but one of the agencies tried to disassociate themselves from the study once it became public knowledge. One Alabama State Health Officer claimed that "somebody is trying to make a mountain out of a molehill," thus minimizing the damage done (1973).

The study lasted 40 years, from 1932 to 1972, with the goal of determining the effect of untreated syphilis on the human body. There were over 600 human subjects, all African American males. Most were poorly educated and living with less than adequate financial

resources (Final Report of the Tuskegee Syphilis Study Ad Hoc Panel, 1973). The African American men were all above 25 years of age and had not received any previous treatment for syphilis. A total of over 1,782 African American were serologically examined. From this group, 472 were syphilitics and were selected for the study(1973). Dr. Jay Katz, Professor of Law and Psychiatry at Yale Law School stated in the Final Report of the Tuskegee Syphilis Study Ad Hoc Panel that "there is ample evidence in the records available to us that the consent to participation was not obtained from the Tuskegee Syphilis Study subjects, but that instead they were exploited, manipulated, and deceived" (1973). These men were not aware of the study, nor of their participation in it. The study group was comprised of "farmers who owned their homes, renters who were considered permanent residents, and day laborers on farms in sawmills. They were predominantly men with families who had acquired responsibilities and had become well integrated into community life and a folk culture which responds to change very slowly" (Report of the Alabama Committee to the United States Commission on Civil Rights, 1973).

The volunteers participated in the study because of the incentives which included burial assistance to their families (in exchange for agreement to an autopsy), physical examinations, and free hot meals on the days of their examinations. In cases of need, referrals were made to other doctors for medical attention when other ailments were found to be present. These incentives were thought necessary because of the "low educational status of the majority of the patients. The majority of the men had only a sixth grade education, but almost a quarter of those interviewed had no formal education" (1973). One could conclude that the lack of education had an impact on the subjects' social

status and access to financial resources, thus explaining why the incentives were offered and accepted.

The Civil Rights Commission's literature review of the study identified three reasons Tuskegee-Macon County was chosen for the study. The first reason was that Tuskegee had a constant population of people who did not often relocate. Most of its residents were homesteaders who were settled or landowners with community ties. "Macon County's selection apparently paid off, for in 1954 '...only 66 of the known 331 living patients in the study had moved out of the county" (1973). The second reason points to the reported syphilis problem within African American communities. Literature reported the high prevalence of syphilis among African Americans "primarily because of the admittedly poor health care historically available" (1973). There was a high prevalence of syphilis in Macon County. The third reason was due to availability to health services and facilities. Tuskegee Institute's John A. Andrew Memorial Hospital was an African American segregated facility. Access to a facility with an expertise in serving an African American clientele was limited. For these reasons, Macon County was an ideal setting for the study.

I previously addressed whether the participants were cognizant of their involvement in the study. My supplemental question, relative to the first, addresses whether the men knew that they had syphilis.

They [the patients] were told they had 'bad blood.' This was the common terminology for syphilis at that time, both in the South and in other parts of the country. 'Bad Blood' was the word that was used for syphilis. So they were told...

Even in the mid '50's, this was the terminology for syphilis –'bad blood.' If you had anemia, it was 'poor blood.' But the health education efforts at the time were such that if you wanted to tell blacks in the South that they had syphilis, you told him or her that they had 'bad blood' and this was the way it was communicated (Report of the Alabama Committee to the United States Commission on Civil Rights, 1973:8).

Although this excerpt was taken from an interview with the director at the CDC, there was no documentation supporting this claim or that the participants fully understood the complexity associated with syphilis (Final Report of the Tuskegee Syphilis Study Ad hoc Advisory Panel, 1973).

When the Tuskegee Syphilis Study became public knowledge in 1972, Americans (particularly African Americans) could not believe such inexcusable, inhumane acts were conducted by the United States government. Many believed they could no longer trust the government, doctors, or the healthcare system. This study perpetuated beliefs surrounding governmental plots to eliminate African Americans through scientific/medical experimentation. The racism and exploitation of African Americans in the study reinforced the feeling of being dispensable in the eyes of the U.S. government. Similar feelings exist 25 years later.

Many of the reverberations heard in African American communities regarding HIV/AIDS echoed the sentiments surrounding the Tuskegee Syphilis Study. The idea that AIDS is a governmental plot whereby the virus is given to gay men with hopes of its spreading to African Americans can be heard today. The theory behind the plot is to rid society of gays,

African Americans, and “other undesirables.” Many gay/bisexual African American men feel that if they avoid having sex with European American men they will not be susceptible to HIV infection. Heterosexual African Americans summarize HIV/AIDS as “their” (meaning European American) disease only transmittable among gay men. These myths continue as HIV/AIDS transmission rates rise among African Americans.

The Tuskegee Syphilis Study, coupled with racism and other historical events, heightened African Americans’ suspicions of the United States government and the healthcare system. These events have posed barriers for African Americans receiving HIV/AIDS prevention messages. The collaborations created to successfully implement and carry out the Tuskegee Syphilis Study have led some African Americans to question the origin of HIV/AIDS and question whether HIV/AIDS is a governmental conspiracy. Finally, in the Tuskegee Syphilis Study the participants thought that they were receiving medical assistance for physical ailments. Through association, African Americans are skeptical about being tested for HIV antibodies. They wonder if the virus is actually being injected into their bloodstreams as opposed to having blood withdrawn.

As a prevention specialist at POCAAN, I engaged in many conversations addressing the questions previously mentioned. Whether fact or fable, the conspiracy theory was and continues to be, an everyday reality for African Americans. This reality is based on historical fact and is felt today. Individuals working to increase HIV/AIDS prevention and education among African Americans will have to address these issues and other barriers confronting African Americans. Chapter 3 explores this topic.

Chapter 3

HIV/AIDS, EDUCATION, PREVENTION

Human Immunodeficiency Virus (HIV) is the virus that causes Acquired Immune Deficiency Syndrome (AIDS). This definition to describe the relationship between HIV and AIDS has been widely used, but what does it mean? How is HIV/AIDS transmitted? Why are African Americans being infected by this virus in such high proportions? What puts this community at higher risk than others? Are funding sources impacting the increase of HIV/AIDS? Finally, what are the racist overtones within each of these questions? All of these items will be answered in this chapter.

HIV is the virus that attacks the immune system and may eventually cripple the body's ability to fight disease. As the disease progresses, the immune system erodes and becomes defenseless against opportunistic infections. AIDS is potentially the end result of the HIV infection. "People infected with HIV are diagnosed as having AIDS if they develop certain serious diseases or conditions such as pneumocystis carinii pneumonia (PCP), Kaposi's sarcoma (a rare skin cancer) or HIV dementia" (National Conference of State Legislatures, 1996). There are also other indicators: a positive HIV antibody test, severe damage of the immune system, pulmonary tuberculosis, invasive cervical cancer and recurrent pneumonia (1996). There are a total of 29 opportunistic infections or conditions in the AIDS case definition.

An estimated 900,000 individuals residing in the United States are infected with HIV, but have not developed AIDS. Some people with HIV who do not have AIDS experience

symptoms of illness and may require health services or may take medicines to prevent opportunistic infections (1996).

The principle modes of HIV/AIDS transmission are through:

- sharing needles or syringes
- having anal, oral or vaginal sex
- a baby's exposure to its infected mother during pregnancy or delivery
- drinking breast milk

These activities must be engaged in with an HIV positive person in order to transmit HIV (American National Red Cross, 1995). HIV enters the bloodstream through open cuts, sores or breaks in the skin, through mucous membranes or through direct injection (National Conference of State Legislatures, 1996).

AIDS is now the leading cause of death among African Americans between ages 25 and 44, greater than homicide, heart disease and accidents combined. The disease long associated with European American gay males is slowly devastating African American communities claiming more men, women and children everyday. It is a silent killer (Mayer, 1997). The United States Department of Health and Human Services' "HIV/AIDS Surveillance Report" states that 28,775 of the 69,151 reported AIDS cases are African Americans, and 26,327 are European Americans, (cases are reported as 100,000 population). These statistics represent an increased rate of 89.7% for African Americans and 13.5% for European Americans since the onset of the disease. African Americans make up 12% of the United States' population and comprise 34% of all reported AIDS cases. Among African Americans, 55% of women and 58% of children make up the 34% of reported AIDS cases (National Conference of State Legislatures, 1996).

In Seattle-King County, epidemiological data indicates that HIV/AIDS has disproportionately affected African American, American Indians/Alaska Natives, and Latinos compared to European Americans or Asian/Pacific Islanders. AIDS cases in People of Color make up an increasing proportion of all cases in King County, rising from 12% of cases prior to 1990 to 17% in 1990-1992 and 21% in 1993-1995. This trend has been greatest among African Americans, and Latinos. AIDS cases among these populations is twice that of European Americans in King County. The average annual AIDS case rate per 100,000 people as of July 1996 was 69.6 for African Americans and 32.5 for European Americans (Seattle-King County Department of Public Health, 1996). Statistics for Seattle-King County parallel national AIDS case statistics. This data indicates that European Americans have managed to stabilize the number of AIDS cases in their communities, whereas African American AIDS cases are on the rise. Washington state law requires AIDS case reporting, whereas HIV infection reporting is not mandatory. However, since the statistics demonstrate that AIDS cases are on the rise among African Americans, it is possible to infer that the number of HIV infections are also on the rise.

Although African Americans are viewed as one group, this category encompasses and covers a wide spectrum of people: upper class, lower class, Christian, Muslim, inner-city, suburban, descendants of slaves and recent Caribbean immigrants. Current epidemiological surveillance does not include social, cultural, economic, geographic, religious, and political differences which may more accurately predict risk.

African Americans are at high risk of HIV infection not because of being genetically predisposed to the virus but because of engaging in risky behaviors (DeCarlo & Peterson, 1995).

Injection drug use had played a major role in HIV infection among African Americans. African Americans are twice as likely as whites to have used drugs intravenously, and HIV infection is higher for black IDUs [intravenous drug users] than white IDUs. One reason may be the "ghettoization" of blacks in inner-city areas where drug trafficking, unemployment and poverty, among other factors, have assured that blacks suffer high rates of addiction. Studies of drug users that describe significant association between health and race may be better explained by these characteristics of the social environment (1995).

HIV transmission among African Americans is primarily viewed as a problem among heterosexual IDUs and their sexual partners. National statistics show that 36% of AIDS cases are a result of male homosexual/bisexual activity and 38% resulted from injection drug use. So the question then becomes, what puts African Americans at risk?

This question is difficult to answer because little information exists on risk factors specific to African Americans. There has been a lack of research in this area. "Funding agencies have not targeted African Americans as a particular area of concern for research" (DeCarlo & Peterson, 1995). In fact, less than 3% of National Institute of Health research grants are awarded to African American researchers and few European American researchers have shown ongoing interest in intervention work with African Americans. Nonetheless, the National AIDS Behavioral Survey indicated:

Among African American adults living in cities with a high prevalence of AIDS cases, almost one fifth (19%) reported having two or more sexual partners in the past year. More men (30%) than women (10%) reported multiple partners. Substantial proportions of blacks with multiple partners used no condoms with either their main (47%) or secondary partners (35%) (1995).

Considering that unprotected sex with an HIV positive person is a mode of transmission and this study was conducted in cities with a high rates of AIDS, there is a correlation

between this type of behavior and a high risk for HIV infection. Since statistics show that HIV transmission rates are rising among African Americans, a key question is why don't people use HIV/AIDS prevention methods? To answer this question one must first look at who is disseminating HIV prevention messages.

European American gay men have dominated the AIDS service and prevention industry since the introduction of AIDS 15-20 years ago. They have been responsible for educating, informing and disseminating HIV prevention messages. They have stabilized transmission rates within their own population, as rates have increased in others. With the limited number of African Americans working in this field, European American gay males have lacked effectiveness in disseminating HIV education and prevention messages to People of Color. The person disseminating HIV messages has a profound impact on how prevention messages are received. European American gay males have been successful in articulating prevention messages to educate themselves. They have codified messages in a way that is well-received by other European American gay males.

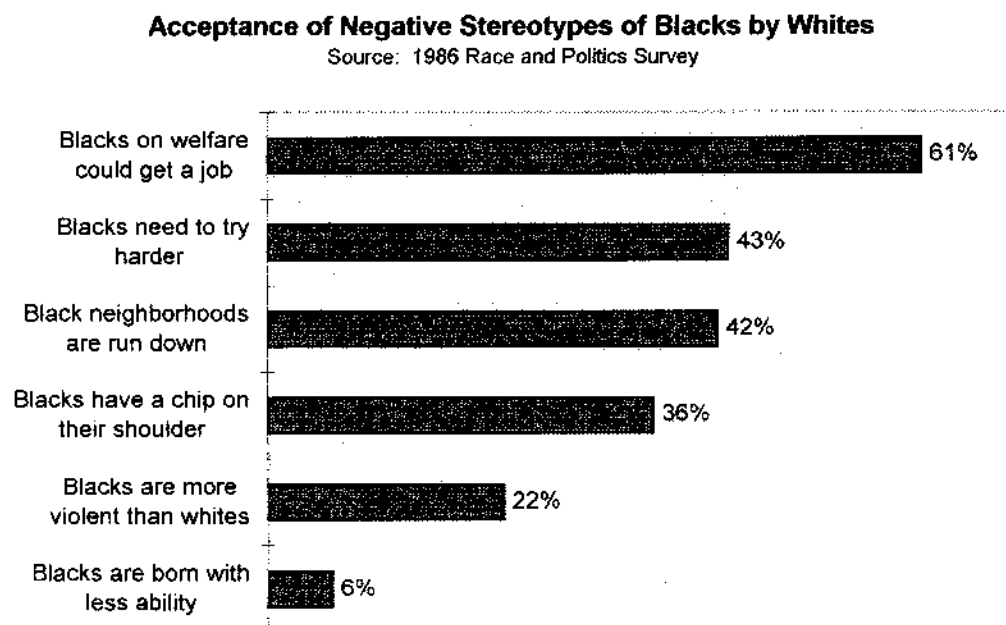
Cultural sensitivity to African Americans has been ignored when HIV prevention messages are created and publicized. This is to say that many of the prevention messages encourage people to stop practicing risky behaviors but lack a cultural link. The problems with this approach for African Americans have been 1) identifying what risky behaviors are, 2) providing alternatives to risky behaviors, 3) detailing the consequences of HIV infection, 4) building a strong case establishing that everyone is at risk for HIV infection if they practice risky behaviors, 5) lack of representatives and representation of targeted groups in messages targeting specific populations, and 6) framing messages in a culturally relevant

context with values that are shared among African American. These factors will be further detailed in Chapter 5.

Internalized superiority and internalized racism, in the form of stereotyping, also create barriers to reaching African Americans with HIV prevention messages.

...whites no longer will openly express a frankly derogatory characterization of blacks certainly not when talking to a stranger. A generation ago, many whites indisputably felt that blacks were inferior, and felt at liberty to say so. What is changed, it is suggested, is not how they feel toward blacks but what they feel free to say about them (Sniderman & Piazza, 1993).

Sniderman and Piazza surveyed these attitudes in a poll.



If individuals hold these attitudes/stereotypes about African Americans, whether members of the dominant or targeted groups, these attitudes/stereotypes impact behaviors which hinder African Americans from receiving HIV/AIDS prevention information. Negative stereotypes, attitudes and behaviors also influence HIV/AIDS funding in African American communities.

AIDS service organizations were started and have been maintained by European American gay males with more than adequate financial resources to care for their own. These men travel in social circles with people of the same financial means. "Most [AIDS service organizations] remain white-controlled, although shifting demographics and pressure from People of Color have forced them to broaden the focus of their services. Many activists of color charge that well-connected ASO's use their fundraising prowess to attract big-dollar, private donors and fat foundation and government grants, diverting the money from the neighborhood CBO's [community based organizations] that, they argue, could best serve those populations [communities of color]"(Suggs, 1997). African Americans do not have the same of financial resources or networking possibilities as their European American counterparts. Many HIV/AIDS funders are unaware of the need for targeted prevention messages for African Americans. Leo Rennie, a former senior policy analyst at the Gay Men's Health Crisis who is currently the director of Brooklyn's People of Color in Crisis, says we have our own family, religious and other traditional values that have to be a part of any initiative (1997). The lack of funding and lack of funder's cultural sensitivity is a cog in the mechanism of racism. Without money for targeted HIV prevention messages, agencies will not create culturally sensitive messages.

Racism has a profound effect on how and why HIV/AIDS transmission is rising among African Americans. Racism impacts who disseminates the messages, what the messages say, where the messages are placed, how they look, who is represented in them, and who funds them. All of this results in African Americans either not receiving appropriate HIV/AIDS messages or hearing and reading messages and feeling that they don't apply.

Chapter 4 transforms this theoretical perspective into the practical realm. This chapter is based on interviews of Seattle/King County African American residents.

Chapter 4

RESEARCH AND EVALUATION

The basis of this research stems from the thesis question: Does personal, cultural and institutional racism effect HIV/AIDS transmission among African Americans in Seattle-King County, and if so, how? Consequently, how does it effect HIV/AIDS education and prevention, outreach efforts in African American communities, and how do African Americans receive education and prevention messages? This chapter introduces a qualitative format that combines designs by Creswell (1994) and Marshall & Rossman (1989) to gather data and process this information. The following outline details my approach to this chapter:

- Introduction
- Definitions
- Delimitations and limitations
- Significance of the research
- Role of the researcher
- Data collection techniques/procedures
- Data analysis strategies
- Reporting the findings
- Summary

Introduction

There are basic assumptions about the qualitative paradigm of research that lay the foundation of my work. I have borrowed these assumptions from Sharan Merriam's Case Study Research in Education: A Qualitative Approach (1988) which state that:

- 1) Qualitative researchers are concerned primarily with **process**, rather than outcomes or products.
- 2) Qualitative researchers are interested in **meaning**—how people make sense of their lives, experiences and their structures of the world.
- 3) The qualitative researcher is the **primary instrument** for data collection and analysis. Data are mediated through this human instrument, rather than through inventories, questionnaires, or machines.

- 4) Qualitative research involves **fieldwork**. The researcher physically goes to the people, setting, site, or institution to observe or record behavior in its natural setting.
- 5) Qualitative research is **descriptive** in that the researcher is interested in process, meaning, and understanding gained through words or pictures.
- 6) The process of qualitative research is **inductive** in that the researcher builds abstractions, concepts, hypotheses, and theories from details.

Each of these assumptions directly related to the nature of this study. I was interested in assessing what Seattle-King County African Americans knew about HIV/AIDS transmission and how that information was acquired. Examining how people make sense of this information and identifying the barriers that prevent African Americans from getting HIV/AIDS information was my concern. There are two obstacles which may prevent informants from receiving HIV/AIDS information: racism and familiarity with the Tuskegee Syphilis Study. I, as the sole researcher, went into the field to obtain the research data. I have analyzed interviews through data reduction and interpretation. This happened simultaneously with data collection. The descriptive and inductive portions of this research are presented in the summary at the end of the chapter. The thesis question was appropriate for a qualitative design because there is little known literature or theory written about this topic. In addition, this study brings the disciplines of intercultural studies and healthcare prevention together to address a growing health care issue.

Definitions

To establish a common language and mutual understanding of concepts, I will define terms as they are used in the study. In the first question of the HIV/AIDS survey, I ask informants to identify their gender. The categories are male, female, and transgender. Transgender refers to someone who was born male or female yet identifies as a member of the opposite gender. Racism, in this context, is used to mean the conscious and unconscious

attitude and/or belief that European Americans are superior to People of Color. This definition covers the spectrum from blatant acts of discrimination to insidious, systemic oppression.

Limitations and Delimitation

The delimitation or scope of the survey is confined to African Americans who reside in Seattle-King County with a minimum age of 15. The limitations included: 1) the informants may not be a true sampling of Seattle-King County's African Americans thus misrepresenting HIV/AIDS knowledge, 2) the sample size may be inappropriate, and 3) the data analysis is subject to alternative interpretations.

Significance of Research

A study that examines the effects that racism has on HIV/AIDS prevention is significant for four reasons: 1) the study provides alternative models of outreach that may be applied to African Americans and other underrepresented groups, 2) demonstrating the value of cultural awareness/sensitivity in HIV/AIDS prevention messages influences how the messages are presented, delivered, and received, 3) this study has the potential to alter how AIDS prevention agencies operate, and 4) the greatest significance is in potentially decreasing HIV/AIDS transmission rates among African Americans. The significance of this particular survey is to 1) assess the general knowledge of HIV/AIDS among African Americans, 2) determine if African Americans identify the effects that cumulative racism has on their knowledge of HIV/AIDS and 3) weigh the influence that the Tuskegee Syphilis Study has had on African Americans knowledge surrounding HIV/AIDS.

Role of Researcher

My past experience with HIV/AIDS, my familiarity with the topic, the setting and the informants play a significant role in how I view the subject. These items highlight my biases, values, and judgments. These are the filters I use to interpret the data. The following is a narrative that summarizes my familiarity with the topic.

The Researcher

I am a gay identified, African American male. Since first coming to terms with my sexual orientation, I have become aware that certain sexual behaviors could put me at risk for HIV/AIDS infection. This awareness became reality when in April of 1996 my partner of seven months was diagnosed HIV positive. I believed that HIV/AIDS was a disease that affected other people, not me. Until then I never knew anyone with the virus and prided myself on taking the necessary precautions to avoid becoming infected. We were tested simultaneously for HIV antibodies and my results returned HIV negative. Nonetheless, unknowingly, I had practiced behaviors which put me at risk. My knowledge of HIV/AIDS increased over the days, weeks, and months to follow. Yet, I constantly questioned why I had been so naive. I considered myself well read and enlightened so why had I placed myself in a position to potentially contract HIV? I continued to gather information, acquire knowledge, and talk about HIV/AIDS transmission among my African American peers. There was an unwillingness to discuss HIV and there appeared to be an absence of information. I realized that information was not reaching African Americans. The posters and 20 second media sound bites had little impact. In Seattle, I visited POCAAN to seek support as a HIV negative partner in a HIV discordant relationship. My experiences at

POCAAN reinforced what I was already feeling. I was informed that prevention messages were not reaching African Americans as well as other communities of color. Working as a prevention specialist at POCAAN, I was able to observe funding, outreach, and personnel disparities which I associated as factors contributing to rising transmission rates among African Americans. My involvement with other HIV/AIDS agencies and committees provided additional insight and exposure to this subject.

The Setting

My familiarity with the setting for data collection evolved similarly. I have been a patron at a hair salon called The SportsCut for the past year. An early observation I made was that the male and female African American clients were from several locations throughout Seattle-King County. In addition, based on conversations I overheard, the clients represented a wide variety of occupations and socio-economic backgrounds. In the past year I had the opportunity to engage in conversations with other clients, the proprietor and hair stylists, thus creating and maintaining a positive rapport. As for my familiarity with the informants at The SportsCut, I knew few of The SportsCut clients by name.

The Informants

Entry into The SportsCut was gained by asking my hair-stylist for permission to conduct interviews on the premises. I explained why I was conducting the study, how the clients could assist in this process, and that I would allow my hair-stylist to read the survey questions to ensure that I would not offend her clients. Indicating that the survey addressed informant's knowledge of HIV/AIDS rather than their sexual behaviors also made entry into the setting nonthreatening. Once consent was granted, I went to the salon

on December 31, 1997 during their busiest hours to conduct the interviews. I chose New Year's Eve because that date is historically busy for African American hair-stylists.

I selected SportsCut patrons based on gender, age, education and average household income per year. I got this information by asking introductory questions that addressed these topics. Ten informants were selected for interviews. Ten was the sample size because they could provide a cross-section of people large enough to detect any patterns that may occur and to gather a wide range of responses. If the patrons did not have the characteristics which met my interview criteria, I was prepared to interview others.

My hair-stylist provided space in the business office to conduct the interviews. The office provided privacy and an opportunity for the interview to take on a conversational tone. Each interview lasted 20-25 minutes.

Data Collection Techniques/Procedures

The data collection involved three steps: setting the boundaries for the study, establishing the protocol for recording the information, collecting information through interviews (Creswell, 1994). The boundaries were set to include African American males and females with the minimum age of 15 living in Seattle-King County. In selecting who would be interviewed for the study, my goal was to have gender equity, at least one gay person, one transgender person, and representation from all of the age groups listed on the survey. My objective was to ascertain the informant's knowledge of HIV/AIDS. Information regarding sexual behavior was not necessary for this study. The survey questions asked informants to recall and identify the sources of their HIV/AIDS information, to relay that information,

and to examine their perspectives on the effects that racism has on HIV/AIDS transmission. Face-to-face interviews were seen to be the best mode of data collection because this would provide direct responses from the informants regarding HIV/AIDS prevention messages. The disadvantage of conducting interviews was that there was no method for verifying whether the data was accurate. Also, the data was filtered through the informants and delivered from the informant's viewpoint. My protocol for the study was to approach the informants, introduce myself, explain the study then ask for their participation. I would then inform them that the interview responses would remain confidential and would only be used for the intended purposes. Finally, I would alert the informants that I would be taking notes and voice recording the interviews so as to increase reporting accuracy.

Data Analysis Strategies

"Merriam (1988) and Marshall and Rossman (1989) contend that data collection and data analysis must be a simultaneous process in qualitative research. Qualitative data analysis primarily entails classifying things, persons, and events and the properties which characterize them" (Creswell, 1994). Data collection and analysis were conducted simultaneously. I assigned codes to each aspect/variable found in the interviews, interpreted the data, and presented it in a table (Table #3 of the Appendix) indicating common themes and patterns. The data analysis was a manual process.

Reporting the Findings

Demographic Profile

The informants consisted of a wide range of socio-economic categories: male(5), female(4), and transgender woman(1). Ages spanned a minimum of 25 years: 15-20(2), 21-29(2), 30-40(5), and 41+(1). The highest level of education completed was: high school(4), a G.E.D.(1), associate's degrees(4), and bachelor's degree(1). Average household incomes per year were: below \$10,000(2), \$10,000 - \$20,000(3), \$21,000 - \$30,000(2), and \$31,000 - \$40,000(3). The informants I selected represented all groups, with the exception of African Americans with advanced degrees and African Americans with average family household incomes above \$41,000 per year. The informant sampling provided an ample cross section of African Americans whereby generalizations and summaries could be drawn from their results. This data appears in Table #1 of the Appendix.

Interview Results

The following results include the interview questions, followed by the informants' responses. The responses are represented in percentages, accompanied by numerical rankings where multiple responses were given. Table #3 of the Appendix provides an overview of the responses.

Question #1: What is HIV? Fifty percent indicated partial knowledge, thirty percent indicated no knowledge, and twenty percent indicated complete knowledge of understanding what HIV is. Informants in both the partial knowledge and the complete knowledge categories stated that HIV is a virus. The complete knowledge group was able to

identify that it is the virus that causes AIDS. Few were able to identify it as the Human Immunodeficiency Virus.

Question #1b: What is AIDS? Fifty percent had complete knowledge while the remaining fifty percent had no knowledge. The fifty percent with complete knowledge were able to define AIDS as the Acquired Immune Deficiency Syndrome. They were also aware that AIDS had a devastating effect on the body's T-cells, thus rendering the immune system defenseless. Those with no knowledge had difficulty differentiating HIV from AIDS. Others in this category associated opportunistic diseases with AIDS, but could not explain how or why people living with AIDS were more susceptible to opportunistic diseases.

Question #2: How is it transmitted? Seventy percent had partial knowledge while thirty percent had complete knowledge and could name all modes of HIV transmission. It was common in the group with partial knowledge to identify unprotected sex, sharing needles and blood transfusions as modes of transmission. Two of those informants identified bodily fluids as a mode of transmission. When asked which bodily fluids, they replied phlegm, mucous and stool.

Question #3: Where did you learn this information? The informants offered multiple responses to this question. There was an eighty percent response rate indicating from the media {television, books, magazines}, sixty percent replied school {high school, college}, twenty percent said in the workplace, twenty percent said in hospitals, and ten percent replied conversations with people infected with HIV. A variety of sources provide HIV/AIDS information. Of the eighty percent who identified the media as a source of information, seventy percent reported the television as one of their sources. Television news programs was a primary source.

Question #4: Do you and your friends talk about HIV/AIDS? If so, what do you discuss? Sixty percent discussed HIV/AIDS with friends, forty percent did not discuss HIV/AIDS with friends. The multiple topics discussed with friends varied. There was a forty percent response rate indicating that they discussed prevention practices, thirty percent replied that they had discussed modes of transmission, twenty percent said they discussed the impact of HIV/AIDS on African Americans, and twenty percent said that they discussed providing support for someone infected with HIV. The informants indicated that prevention practices were discussed and modes of HIV/AIDS transmission were part of their conversations. Informant #3 felt that as a single, African American female, she had to discuss safety and HIV/AIDS in order to date. Informant #5 expressed that HIV/AIDS rarely came up but felt that he and his peers were aware of HIV/AIDS. Informant #4 said that in a one-year period he and his peers discussed HIV/AIDS maybe three or four times.

Question #5: Has racism impacted your knowledge of HIV/AIDS? If so, how? Twenty percent reported an impact, eighty percent reported no impact. Ten percent reported an impact in data reporting and ten percent reported impact in access to services for African Americans who are HIV positive. Informant #4 felt that HIV/AIDS statistics were stated to show a high prevalence among African Americans. Informant #9 said that African Americans who are HIV positive and seeking services face numerous obstacles because of their skin color.

Question #6: Are you familiar with the Tuskegee Syphilis/Bad Blood Study? Sixty percent reported awareness, forty percent reported no awareness. Many of the informants did not know the study by its original name. Once a brief synopsis was provided or a mention of the movie produced about the study was given, many informants recalled it.

Question #7: Has the Tuskegee Syphilis/Bad Blood Study impacted your reaction to HIV/AIDS? If so, how? Fifty percent reported an impact, ten percent reported no impact, and for forty percent of the informants the question was not applicable. Of those who reported an impact, twenty percent believed that HIV/AIDS, like the Tuskegee Syphilis Study, began as an experiment created to destroy certain communities, ten percent reported the use of experimental drugs for HIV paralleled the experimentation demonstrated in the Tuskegee Study, ten percent felt the Tuskegee Study increased/heightened the awareness of monitoring healthcare, ten percent drew correlation between the limited information about the Tuskegee Study and HIV/AIDS. Informants #3 and #7 drew parallels between the Syphilis Study and HIV/AIDS stating that HIV/AIDS was created in a laboratory experiment which got out of control and the findings were used to destroy undesirable communities. Informant #10 suggested that just as there was a 40 year delay in discovering the Syphilis Study, information associated with HIV/AIDS is also being withheld.

Question #8: Rates of HIV transmission are rising among African American. What do you think should be done to increase knowledge surrounding HIV infection?

The informants provided multiple responses to this question. There was a fifty percent response rate suggesting that there be an increase in general education; fifty percent suggested discussing HIV/AIDS; thirty percent advocated community intervention; thirty percent replied suggested education in schools; ten percent suggested increased education in the workplace; ten percent recommended conducting more surveys; ten percent wanted to see more on television; ten percent wanted increased condom distribution; ten percent advocated for increased personal responsibility, ten percent thought the information should be placed on cereal boxes; and ten percent encouraged practicing monogamy. Many of the

informants identified increased education surrounding HIV/AIDS and talking about it as methods for increasing awareness. Community intervention and increased education in schools were thought to reach a broader spectrum of people. Informant #4 stated, "It should start with the home. Actually, it should start with the workplace and then go home. Information should be given to you at work or through child care services so that information does reach the house. Positive information to the house might save a kid; might even save an adult." Informant #6 expressed, "For one, I wouldn't say that I know one method that should be used to let people know that they too can get it. Anything else other than that we have to bring down a lot of stereotypes surrounding the disease. Until the stereotypes are really broken down, I think for all these reasons that it's going to be a problem." From the range of these responses, it appears that a multifaceted approach with a focus on HIV/AIDS stereotypes reduction will be the most advantageous method of reducing transmission of the disease.

Summary

Knowledge regarding HIV/AIDS seemed to be present in small amounts. This is to say that responses to questions #1 and #2 indicated that people had some information about the topic but could seldom recall complete knowledge about it. This was also the case with naming the modes of HIV/AIDS transmission. Unprotected sex, the exchange of bodily fluids, and blood-to-blood contact were described as modes of transmission. Transmission from a mother to infant during childbirth was mentioned once and breast milk was never identified as a bodily fluid. In addition, other bodily fluids identified by informants have not been reported to transmit HIV. Blood transfusions, as a means of transmission, was mentioned three times and dental instruments carrying the virus and transmitting it was

mentioned. The source of this information stemmed from the high profile AIDS cases that appeared in the media. This reinforces the finding that for many of the informants television was a source of HIV/AIDS information: the ten second sound bites, the television news and news magazine programs provided much of their knowledge.

The data indicates that HIV/AIDS information is obtained from a variety of sources, although informants often retain minimal amounts of knowledge. If people have partial knowledge, then partial knowledge is what is shared when friends discuss HIV/AIDS. I will venture to say that partial knowledge and misinformation are being shared with friends regarding HIV/AIDS. If friends share information and accurate versus inaccurate information is debated, one is uncertain as to which perspective would prevail. Therefore, it isn't possible to draw definite conclusions about the accuracy of information shared among friends. Nevertheless, it is a positive that friends are talking about HIV/AIDS. The reason I consider communication a positive quality is that there exists within the African American community a norm of not talking about sex. One would like to think that if HIV/AIDS prevention and modes of transmission are being discussed, then sex and safety are a part of the discussion because this is where the increased awareness takes place and lays a foundation for behavioral changes. Obviously, this is a created scenario because the Center for Disease Control and the Seattle-King County Health Department state that rates of HIV/AIDS infection are rising among African Americans. This suggests that although informants reported discussing HIV/AIDS transmission, these discussions are not resulting in behavioral changes.

The definition of racism has evolved to mean blatant acts of discrimination. This is also the definition from which the informants were operating. After each interview, I reviewed the interview questions with the informants. When we arrived at the question about racism, I explained how I saw the effects of racism impacting HIV/AIDS prevention messages. My viewpoint broadened their perspective and challenged them to examine insidious cultural and institutional racism as opposed to blatant personal racism.

The Tuskegee Syphilis Study generated responses based on the perception of social oppression. Strong parallels were drawn between The Tuskegee Syphilis Study and HIV/AIDS: the belief that researchers keep African Americans uninformed, using experimental drugs on African Americans to find a HIV/AIDS cure, and creating HIV/AIDS in a laboratory to eliminate society's undesirables. One can couple these notions with the issue of racism and draw a conclusion that racism has had an impact on HIV/AIDS transmission as a result of awareness of the methodology used in the Tuskegee Syphilis Study.

There was a detectable pattern among the informants when asked for suggestions to increase HIV/AIDS knowledge among African Americans. The informants often referred to an ambiguous body, "they," as an outside force which has the power to make changes occur. I believe this speaks to the powerlessness that some African Americans feel as a result of societal racism. Overall, the informants all agreed that something needed to be done to reach African Americans with HIV/AIDS prevention messages. All of the suggestions spoke to the notion that, because of the diversity that exists among African Americans, multiple approaches would be needed to reach the many different segments of the community.

Chapter 5 addresses various approaches that can be used to reach African Americans, regardless of socio-economic considerations.

Chapter 5

EFFECTIVE METHODS

The use of intercultural methodology in HIV/AIDS prevention is essential when considering the numerous cultural borders the virus crosses. As previously discussed, many of the models used in HIV/AIDS prevention were culturally targeted for European American, gay men. This culturally limited 15 to 20 - year old prevention model has resulted in a system that is extremely resistant to change. My Seattle-King County experience has shown that, although statistical trends indicate a higher prevalence of HIV/AIDS in African American and Latino communities, methods to reach these populations have been inadequate. This chapter will focus on an intercultural training design, the POCAAN model, and The Tuskegee Syphilis Study to identify effective methods to reach African American communities with HIV/AIDS prevention messages.

Intercultural Training Design

Derald Wing Sue developed a training design that details an interpersonal, organizational and systemic approach to cultural diversity in the counseling and psychology fields. I have adapted Sue's model to the HIV/AIDS prevention field, demonstrating how it could be used to decrease rates of HIV/AIDS among African Americans.

The principles Sue outlines to achieve cultural inclusion are to a) increase cultural sensitivity, b) obtain greater knowledge and understanding of various racial-ethnic groups, and c) develop culturally relevant strategies for reaching diverse communities (Sue, 1991).

In order to successfully achieve cultural inclusion, an organization must first address the following issues:

- 1) *Organizations must first employ people of different cultures and groups.* As HIV/ADS statistics indicate a higher prevalence among African Americans, it will be necessary to hire more African Americans to get prevention messages to those who are being most effected by the virus.
- 2) *A company that values diversity and employs a diverse workforce retains its competitive edge.* Agencies which have a diverse staff are more apt to engage in creative problem-solving and are better equipped to meet the needs of diverse communities. HIV/AIDS prevention agencies must have employees within their agency who are familiar with the functions of the community in need. This will help to better identify the communities' needs and address them.
- 3) *Organizational behavior differs from country to country, and lack of understanding can lead to major blunders and losses.* Organizational behaviors also differ from one cultural community to another. An effective manager or worker will need to develop special skills and sensitivities to conduct appropriate interactions in target communities.
- 4) *An organization's infrastructure should be analyzed to remove potential barriers to multicultural inclusion.* HIV/AIDS prevention organizations must be willing to include African Americans in decision-making positions and share power in order to strategically develop culturally relevant outreach plans.
- 5) *A significant investment of time, energy, and financial resources must be allocated to develop a truly multicultural organization.*

6) *Workplace education/training must include the needs of diverse communities.*

Differences in learning and teaching styles which may effect worker productivity and effectiveness will need to be explored. Clarifying differences in communication styles between African and European Americans (and other communities of color) should be included in the educational/training process. As the organization meets the needs of African Americans and understands their learning/teaching and communication styles, these skills can be transferred to African Americans outside the agency. Understanding how to communicate prevention messages to African Americans moves one step closer to African Americans hearing the messages.

7) *Ethnocentric European American modes of operation are no longer useful.* This approach has been highly destructive and limiting to African and European Americans alike. Samovar and Porter state that our perceptions of what constitutes appropriate must be expanded to include different modes of operation (1991). This becomes possible by acquainting oneself with equally legitimate methods of social interaction. Utilizing modes of operation which already exist within African American communities allows prevention efforts to be culturally relevant and acceptable to the target population.

Sue's next step is to identify areas within organizations where diversity can be incorporated to begin multicultural inclusion. Recruitment is the first focus. "Organizations must reach out to attract minority workers for recruitment purposes" (Sue, 1994). This is often impeded by any variety of variables, i.e. the image of the company, low representation in the work force, or biased hiring practices. All of these factors need to be analyzed and steps taken to eliminate these obstacles. Once an employee is hired, the next step is to keep him/her in the workplace.

While recruitment focuses on the labor pool, retention addresses the corporate culture of the organization. Cultural differences must be embraced by HIV/AIDS organizations to make African Americans feel comfortable in the workplace. African Americans must perceive themselves to be a part of the team. To simply recruit African Americans is not enough. Making organizational changes to the agency's culture will have long term, beneficial effects. African American workers will feel respected and valued in the workplace and will be more productive. In addition, managers and workers need to understand the experience of African Americans and feel comfortable in dealing with unpleasant, racial-cultural issues arising from cultural diversity. The absence of change in the organization's culture results in misunderstandings, frustrations, and loss of a valuable and diverse workforce. Sue states, "Oftentimes, minorities who are the victims of discrimination and oppression may need economic, social, and emotional support not needed by non-minorities" (1991). This reality speaks to the fact that culturally relevant support services should be available for the well being of African American employees that will prove to be beneficial to the organization over time.

Many African Americans within HIV/AIDS prevention organizations speak to the fact that advancements and promotions within their agencies are limited. For example, within the Seattle-King County HIV/AIDS Prevention Division, there are a total of 188 employees, 14 (7.5%) of whom are African Americans. There are no African American officials & administrators in decision making positions. Of the African American employees, four are professionals, one is a technician, five are office clerical staff, and four are paraprofessionals (Seattle-King County Department of Public Health, 1997). Equal access

and opportunity for advancement and promotions will mean recognizing and understanding different experiences, values, and behaviors of People of Color (Sue, 1991). Recognizing these differences also means that the current, traditional paradigms for defining leadership will need to be redefined. Being a middle-class, European American, ivy-league school graduate cannot be the only criteria for identifying leadership abilities. This criteria is limiting to most African Americans when one considers, for example, the number of African Americans who have graduated from "Ivy League" schools.

Recruitment, retention and promotion are internal functions of an organization. These recommendations to the organization may be met with some degree of resistance which Sue categorizes into three headings: difference, interpersonal discrimination, and systemic barriers.

Difference refers to the variances found in communication styles and in characteristics of racial-ethnic groups. Difference may be present in an organization's beliefs that African American traits, attitudes, behaviors and values clash with those of HIV/AIDS prevention agencies. Actually, it is institutional policies and practices that are the source of the problem. Effectiveness training for minority and majority individuals is what Sue recommends to address this barrier (Sue, 1991).

Interpersonal discrimination, prejudice, and (in this case) racism prevents multicultural inclusion from taking hold within HIV/AIDS organizations. Beliefs that African Americans are less suitable for positions than are European Americans works in opposition to diversity initiatives. Buying into stereotypes which perpetuate negative images of African

Americans promote conscious and unconscious discriminatory behaviors. Here I reiterate the point that if European American workers can overcome their negative stereotypes of African American co-workers, then working with African American clients will be less of a stretch beyond the confront zones of European Americans. Sue says that training at this level focuses on interpersonal interaction along with attitude and behavioral changes. Training sessions aimed at consciousness raising, increased knowledge, increased sensitivity, and developing cross-cultural counseling, teaching, and management skills are needed to eradicate racial discrimination barrier (1991). I would also add training in cross-cultural outreach models to Sue's recommendations.

Sue states, "Systemic barriers that mirror the nature of race relations in the United States may also exist in an organization" (Sue, 1991). Having European Americans as sole leaders within HIV/AIDS organizations poses structural problems as to how African Americans are evaluated in the workplace and at what speed outreach efforts targeting African Americans will be designed and implemented. Diversification means altering the power relations and structure of the organization to decrease the amount of systemic oppression. Organizational development, systems intervention, and creating new programs and practices are the recommendations Sue offers to overcome systemic barriers. The chart below illustrates different types of training or interventions that may be most appropriate for the potential challenges facing organizations (1991).

FUNCTIONAL LEVELS	BARRIERS		
	Differences	Interpersonal Discrimination	Systemic Barriers
Promotion/ Advancement (Career Path)	Effectiveness training for minorities and majority individuals.	Consciousness raising Sensitivity training Increased knowledge Cross-cultural counseling, teaching, [outreach,] and management skills	Organizational Development Systems Intervention Creating new programs and practices
Retention (Corporate Culture)	Effectiveness training for minorities and majority individuals.	Consciousness raising Sensitivity training Increased knowledge Cross-cultural counseling, teaching, [outreach,] and management skills	Organizational Development Systems Intervention Creating new programs and practices
Recruitment (Labor Pool)	Effectiveness training for minorities and majority individuals.	Consciousness raising Sensitivity training Increased knowledge Cross-cultural counseling, teaching, [outreach,] and management skills	Organizational Development Systems Intervention Creating new programs and practices

Cultural Diversity Training: A Systemic Approach (Sue, 1991)

Whereas Sue's model offers training and interventions as a means of implementing multicultural inclusion throughout an organization, the POCAAN model looks at methods of outreach and education to decrease HIV/AIDS transmission among People of Color. The unique aspect of POCAAN's model is its ability to have a basic multicultural design that takes on various forms depending on the needs of the target community.

POCAAN

POCAAN's mission is "to develop, implement and promote comprehensive multicultural HIV/AIDS prevention models that are effective and responsive to the evolving needs of communities of color" (POCAAN, 1996).

POCAAN's approach to communities of color is composed of a multiple strategy ranging from the identification of the issues within the communities to the establishment of risk education programs and support services which motivate behavioral change for people engaging in high risk behavior. This creates an environment in which these new behaviors can be maintained. Such an approach includes strategies for organizing individuals within the communities and mobilizing community based organizations and public institutions to work together to break down the barriers to the success of the approach and requires programmatic commitments as well as increasing levels of financial support for these efforts (POCAAN, 1996:1).

This model is four-pronged. It includes community organizing, community-based education and outreach, peer education, and community-based services liaison.

Community organizing is focused on institutional and attitudinal change through education and empowerment. Educating community agencies as to the behaviors which put people at risk for HIV/AIDS transmission is an essential component to community organizing. Once agencies are aware of these behaviors they can convey this knowledge to their clients while also making the client aware of POCAAN and its mission. Community organizing may be, for example, working with the Seattle Young People's Project (an agency whose mission is to empower youth) teaching the youth safer sex and harm reduction practices. While the agency has high European American youth involvement, it is important that community organizations reach African Americans, regardless of the numbers.

Community-based education and outreach (street outreach) targets individuals practicing high risk behaviors in community settings (1996). This approach takes prevention messages into the community as opposed to community members coming to the agency. This is a shift in paradigms. HIV/AIDS transmission is highly concentrated among African American children, heterosexual women and intravenous drug users. Street outreach may take place at schools or on city streets during lunch hour.

Peer education enlists members of the target populations to act as educators and to provide support for behavioral change among their peers (1996). Utilizing pre-established relationships with individuals and communities to relay prevention messages reaches populations practicing risky behaviors through person-to-person, face-to-face contact . This non-authoritarian perspective allows information to be disseminated using culturally appropriate language and communication styles.

Community-based services liaisons create links between at-risk individuals and community services, and provide advocacy within systems to ensure barriers to access are addressed and systems change. With community-based services liaisons, collaborations reduce systemic barriers while decreasing HIV/AIDS transmission. This early prevention method looks at the circumstances that may contribute to an individual practicing high risk behaviors and works to ameliorate the situation. This may include working with a women's resource center to reach African American women who may think that they are not at risk of HIV infection.

POCAAN's model reaches People of Color where they are: physically, mentally and socially. The model allows multicultural principles to play a significant role through relevant communication, specific language and cultural awareness/sensitivity.

Tuskegee Syphilis Study

The Tuskegee Syphilis Study can be considered as an ideal model of cultural relevance in the healthcare system. This is not to disclaim the cruelties that resulted from the study but to highlight the cultural relevance used to reach African American men. Several factors contributed to the success of the Tuskegee Study. There was research conducted on the target population; collaborative efforts were coordinated on local, regional and national levels; the incentives offered appealed to the socio-economic level of the subjects; culturally appropriate language was used; and African American staff members were available to conduct the study.

The Tuskegee Study began with the discovery that syphilis was the number one cause of draft rejections among registrants during World War I. African Americans were reported to account for five times more positive syphilis tests than the national average (Report of the Alabama Commission on Civil Rights, 1973). In the late 1920's, private foundations conducted studies on health in the South. Other foundations later provided funding to conduct blood tests on African Americans in Macon County. Both instances demonstrate the significance that research played in targeting African Americans for the study. If African Americans were the focus of studies for HIV/AIDS prevention, I venture to say that great inroads could be made to decrease HIV/AIDS transmission.

Tuskegee Study coordinators were successful in drawing to the project local, regional, and national supporters. Tuskegee morticians, Tuskegee Institute's John A. Andrew Memorial Hospital and the local Veteran's Hospital endorsed the study by providing services and facilities. Regionally, the Macon County Health Department, the Alabama Health Department, and the Macon County Medical Society were supportive by providing counsel and supervision over the study. The USPHS, which made the study an official program, and the Milbank Memorial Fund, which provided funds for burial and autopsy expenses, provided national support. The same could be done with HIV/AIDS prevention research. Millions of dollars have been raised and numerous studies conducted on HIV/AIDS. Local, regional, and national support for decreasing HIV transmission among African Americans would raise this concern to a national priority. With national support, this crisis would create synergy and momentum to develop effective methods to impact HIV transmission.

Burial and autopsy expenses, medical services, hot meals, and transportation were all incentives for participation in the study. Each of these incentives appealed to the socio-economic level of the study's participants. Many of them were farmers, therefore providing medical and financial benefits along with hot meals and transportation met their needs. Suitable incentives for African Americans based on their socio-economic levels could and would attract African Americans into agencies to have HIV/AIDS testing and counseling and to receive HIV/AIDS information.

Bad Blood was the term used by African Americans. The terminology was also adapted by healthcare officials during the study. Using language familiar to the target population demonstrated cultural relevance. Applying this principle to HIV/AIDS prevention messages

is also useful. Talking about condoms, sexual minorities, and harm reduction in communities where these terms are not used does little in the area of HIV/AIDS prevention. Using culturally appropriate language delivers the message and the message has meaning.

The USPHS also solicited the support of Tuskegee's African American hospitals and its staff to work with the study's participants. The USPHS officials also chose a facility where the subjects had pre-existing relationships with the staff. Employing the service of African American staff members helped make entry into the study more acceptable. The subjects were more likely to return for medical examinations, and more apt to accept the incentives. In addition, it also added to the subjects level of comfort. I have heard many people say that having another African American assist them in stores, offices or other service industries eases their anxiety. The same is true of HIV/AIDS prevention. The greater the representation of African Americans in the prevention field the more inclined people will be to hear prevention messages.

Summary

There is no one method that is the most effective model for decreasing HIV/AIDS transmission among African Americans. Sue's, POCAAN's, and Tuskegee's models offer examples of organizational, programmatic, and culturally competent approaches for addressing the problem. Each of the models has cultural inclusion and multicultural awareness/sensitivity as its basis. These are principles that can be taken from the intercultural field and used in HIV/AIDS prevention. National statistics indicate that HIV/AIDS cases are rising among African Americans and these multifaceted approaches

will assist in reducing transmission. The models should be applied to HIV/AIDS organization with consideration for the organization's culture and level of multicultural awareness.

Chapter 6

IMPACT OF FINDINGS & RECOMMENDATIONS: What Does All of This Mean?

This chapter deals directly with the following questions: Does personal, cultural, and institutional racism effect HIV/AIDS transmission among African Americans in Seattle-King County, and if so how? How does it effect HIV/AIDS education, prevention and outreach efforts in African American communities? How does it effect how African Americans receive education and prevention messages? The previous chapters discussing racism, the Tuskegee Syphilis Study, barriers to HIV/AIDS education and prevention, data generated from community interviews, and effective methods to decrease high rates of HIV/AIDS transmission among African Americans all contribute to the responses to these questions.

Racism, as pointed out in Chapter 1, has had a tremendous impact on American society and hence, HIV/AIDS transmission. Racism played a major role in the Tuskegee Syphilis Study and today; it is still widespread at personal, cultural, and institutional levels. People who work in the HIV/AIDS prevention field are not free from biases, assumptions, and stereotypical beliefs that exist about African Americans. European Americans have stereotypical beliefs, just as African Americans working in the prevention field, and those receiving prevention messages have them. Whether conscious or unconscious, overt or covert, racism exists and has impacted how African Americans receive HIV/AIDS prevention messages. The political climate of the country in the 1980's set a tone for the perpetuation of racist attitudes and beliefs and we still feel the impact of that era today.

Consequently, this has contributed to the rise in HIV/AIDS transmission among African Americans.

Data generated from the HIV/AIDS interviews revealed that the majority of HIV/AIDS knowledge was acquired through television coverage. None of the informants reported acquiring knowledge from HIV/AIDS prevention workers. One could argue that information may have been provided by a peer educator who did not identify him/herself as such. I would counter that argument by considering that most peer educators announce their agency affiliation while leaving individuals with safer sex and/or bleach kits (used for cleaning intravenous drug equipment). African Americans are seldom reached with HIV/AIDS prevention messages and this blatantly points to personal racism.

Derald Wing Sue suggests that increased cultural sensitivity, greater knowledge and understanding of various racial-ethnic groups, and culturally relevant strategies for reaching diverse communities will help to achieve cultural inclusion and diminish racism (1991). These suggestions can be achieved through training but also through direct interaction with people in underrepresented groups. Agency recruitment, retention and professional advancement are parts of this process. In addition, personal interactions move the concepts from theory to practice. If personal connections are made within an agency, then prevention messages reaching African Americans outside of agencies is more attainable. An agency that has cultural inclusion as its goal will also provide support to encourage human connections, and support for conflict resolution. Sue's model works with employees and agencies in their intellectual and emotional states in regards to cultural

awareness. POCAAN's model works to meet community members where they are, culturally and geographically.

POCAAN's model addresses programmatic cultural sensitivity and combats personal racism. Community organizers, peer education, community-based services liaisons and street level outreach workers create culturally sensitive approaches to HIV/AIDS prevention. This multi-pronged approach reinforces prevention messages if they are heard from a variety of reliable sources. For example, if a person is in a social services setting, he/she may hear the prevention messages. If on a city street, he/she may come in contact with a peer educator. And, if he/she is involved with a local agency, the individual is likely to hear prevention messages from community organizers. All of these encounters require face-to-face interactions. They get the prevention messages to African Americans and directly confront the personal racism through personal interactions.

Using culturally relevant language, having African American staff members, providing appropriate incentives, working in collaboration with other community agencies, and going into the communities to reach African Americans in their own surroundings are all components which move toward developing culturally relevant strategies for reaching diverse communities. The Tuskegee Syphilis Study demonstrated the value of cultural competency by using these components. Although used to violate a group's human rights, the study was successful in this regard. I would expand the point by arguing that if as much energy were used to decrease HIV/AIDS among African Americans as was devoted to the Tuskegee Syphilis Study, there would be a decline in HIV rates among African Americans. Yet, there is still cultural racism to contend with.

The media creates and perpetuates existing culture. Media messages and images seen and heard about HIV/AIDS transmission are targeted primarily for European Americans, specifically gay males. There is limited representation of African Americans in these messages. There are few media messages where people speak about HIV/AIDS in a cultural context or look like African Americans. Two such examples are Magic Johnson and Arthur Ashe, both national sports figures.

Simply stating facts and statistics about HIV/AIDS and advising people to use condoms is not enough. The next step is relating these facts to values commonly shared among African Americans. Historically, the family and community have been the foci for African Americans. Linking statistics, HIV/AIDS prevention facts, the impact of risky behaviors and alternative practices to family/community-centered values demonstrates cultural sensitivity. In addition, having a person who looks, speaks, and is recognized by African Americans to deliver the prevention messages confronts cultural racism and empowers African Americans to educate themselves and their communities.

The informants indicated that "they" (an omnipotent being) should do something to educate African Americans about HIV/AIDS transmission. This illustrates both how and why African Americans should take interest in HIV/AIDS prevention and the costs of ignorance to the community. It gives a greater motivation to be proactive. The messages must also move away from racist stereotypes supporting beliefs that all African Americans are over-sexed, drug users and focus on the unity of the family and positive contribution made as healthy community members. I restate that media-produced HIV/AIDS prevention

messages must be culturally relevant, culturally sensitive, and representative of African Americans. These types of actions begin to address cultural racism and makes HIV/AIDS messages palatable for African Americans. Consequently, these efforts require adequate funding to implement them.

There is a cliché that states “those who have, have, and those who don’t, don’t”; such has been the case with HIV/AIDS funding for African Americans. Limited research has been conducted to explore HIV/AIDS intervention for African Americans. A lack of funding dollars to support these projects is an example of institutional racism in the healthcare system. Dollars generated for HIV/AIDS research have gone to benefit European American, gay men due in part because they started and currently maintain most HIV/AIDS organizations. According to Donald Suggs of POZ Magazine, these men have more than adequate financial resources and travel in social circles of the same stature resulting in access to readily available funds (1997). European American gay men’s interest in HIV/AIDS has been to protect and save people like them. It is an ethnocentric motivation that has impacted how and to what extent African Americans have been served by HIV/AIDS agencies and receive limited funds. Limited funds and research interest focused on HIV/AIDS prevention for African Americans has inevitably resulted in high HIV/AIDS transmission rates. As Leo Rennie of Brooklyn’s People of Color in Crisis states in Suggs’ article that “we have our own family, religious and other traditional values that have to be a part of any initiative” (1997). There has to be financial allocations to explore cultural considerations. Once cultural values have been considered and identified, funding is also needed to develop, implement, and conduct programs. Testing their validity and impact in communities also requires funding. Significant parts of institutional racism lie in the

policies and procedures which give benefit dominant, European American society. Spreading HIV/AIDS dollars to African Americans for research changes funding distribution procedures and works to dismantle institutional racism.

The value of collaborations cannot go unnoticed. The Tuskegee Syphilis Study highlighted the importance of local, regional, and national support. The study continued for 40 years because of the multi-tiered support it received. The officials in the healthcare system were able to change their policies to support the project. They provided medical and financial incentives because of support generated by local and national sources. They used an African American facility to conduct the study, not to mention the meals, staff and transportation provided due to local and regional aid. Just as collaborations were used for the Tuskegee Syphilis Study, similar collaborations must occur to defeat the climbing HIV/AIDS transmission rates. POCAAN's model encourages collaborations on a local level but care must be taken to create regional and national linkages as well.

Insufficient funding is one aspect of institutional racism and the Tuskegee Study proves that measures can be taken to combat this oppression. Nonetheless, twenty-five years after the Tuskegee Syphilis Study, African Americans have maintained some distrust of the healthcare system. This was apparent from the results of the HIV/AIDS survey where informants indicated that, just as there was little regard for the lives of the African American men in the Tuskegee Syphilis Study, they questioned whether HIV/AIDS was created to destroy African Americans. These were sentiments I heard in my role as prevention specialist at POCAAN and also in casual conversations. These feelings are very real for African Americans and will need to be addressed.

Another cliché that states that “trust is earned, not given.” Healthcare and HIV/AIDS prevention workers must work diligently to earn the trust of African American clients. Once again, this requires changing policies, procedures and protocol to work with African Americans. In disseminating HIV/AIDS prevention messages, it may demand taking additional time to establish a rapport, to earn trust and to be taken seriously. It may call for being active listeners as opposed to didactic communicators. Multiple encounters may be needed to establish familiarity and to achieve mutual comfort. These recommendations need to be incorporated into the operational functions of the healthcare system and HIV/AIDS agencies. A proactive stance to eliminate this level of institutional racism will help gain the trust of African Americans, lost as a result of the Tuskegee Syphilis Study.

The evidence presented in this chapter proves that personal, cultural and institutional racism has had an effect on HIV/AIDS transmission among African Americans in Seattle-King County. Whether due to the lack of African Americans who are HIV/AIDS prevention workers, or minimal representation of African Americans in print or recorded prevention messages, or the lack of funding in and multilevel support for HIV/AIDS intervention research, all of these factors contribute to the presence of racism and explain the rise in HIV/AIDS transmission rates among African Americans.

Organizational, programmatic and training recommendations were offered to address the various levels of racism. I also emphasized that none of the recommendations would be possible without adequate funding. Instituting multicultural initiatives require financial and organizational commitment. Without financial and organizational commitment,

cultural inclusion is unachievable and efforts are unproductive. Knowledge can be gathered from The Tuskegee Syphilis Study to prove that cultural awareness and sensitivity have a strong impact on target populations. This information lends itself to be used in HIV/AIDS prevention among African Americans. The outcomes of the study regarding syphilis were used to benefit society. The challenge is to now use the outcomes to battle HIV/AIDS.

CONCLUSION

Limited literature exists that applies intercultural studies to HIV/AIDS prevention. This paper demonstrates the need for joining the two disciplines. African Americans have values, beliefs and language that differ from European Americans. These considerations must be taken into account when developing strategic plans to decrease HIV/AIDS transmission. Taking these facts into account addresses personal, cultural, and institutional racism and moves strategic planning in the direction of dismantling racism and empowering African Americans. Racism effects HIV/AIDS education and prevention and outreach efforts in African American communities, and effects how African Americans receive education and prevention messages. If machines, incapable of internalizing societal messages and imposing social oppression, were disseminating HIV/AIDS information then it would be difficult to make this statement. However, human beings socialized in the United States with racist beliefs are at the helms of many HIV/AIDS organizations. Racism permeates U.S. society and throughout the HIV/AIDS field creating devastating effects that have resulted in disproportionate amounts of AIDS cases among African Americans.

HIV/AIDS organizations, prevention workers, and diversity trainers/consultant would benefit from the findings in this study. The historical perspective offered by the Tuskegee Syphilis Study, the perceived barriers to HIV/AIDS prevention, the multicultural training design and the POCAAN model provide a foundation to begin exploring multicultural inclusion in HIV/AIDS organizations. The information will need to be adapted to the culture of the organization and the community, and will serve to help HIV/AIDS organizations achieve cultural inclusion. A diversity consultant/trainer with the charge of

assisting in the creation of an inclusive HIV/AIDS organization can use this document as a tool to conduct needs assessments and organizational audits.

The use of interdisciplinary knowledge to dismantle racism and decrease HIV/AIDS transmission rates among African American must advance beyond this study. There are many areas of research and questions to explore. For example:

- 1) Once an agency implements culturally inclusive initiatives, what impact will this have on African American HIV/AIDS transmission rates?
- 2) Does being culturally inclusive in the delivery of HIV/AIDS prevention messages effect behavioral change?
- 3) Will cultural inclusion for African Americans apply to other groups of color? What needs to happen to make this a possibility?
- 4) Asking informants specific questions about stereotypes they have about people who have or are at risk of getting HIV/AIDS and determining how this impacts their perceived risk of infection.
- 5) What are African Americans outside of the HIV/AIDS industry doing to decrease transmission rates? What needs to be done?

These topics and more can be examined as an extension of this study.

"Nationally, AIDS is now the leading cause of death among African Americans aged 25-44, surpassing homicide, heart disease and accidents combined" (Seattle-King County Department of Public Health, 1996). It is a silent killer that can only be fought with prevention information and behavioral changes. Racist barriers block African Americans from acquiring this much needed information. Simultaneously, multicultural inclusion creates a supportive structure that encourages the acquisition of HIV/AIDS knowledge and saves lives.

APPENDIX

Table #1 Demographic Profile

	Gender	Age	Highest Level of Education Completed	Average Household Income/year
Informant #1	Male	15-20	1-12	10-20 K
Informant #2	Female	30-40	Associate's	21-30 K
Informant #3	Female	21-29	1-12	21-30 K
Informant #4	Male	30-40	Associate's	31-40 K
Informant #5	Male	21-29	Associate's	10-20 K
Informant #6	Male	30-40	Bachelor's Degree	31-40 K
Informant #7	Female	30-40	Associate's	31-40 K
Informant #8	Male	15-20	1-12	Below 10 K
Informant #9	Transgender	30-40	G.E.D.	Below 10 K
Informant #10	Female	41 +	1-12	10-20 K

Table #2 Interview Schedule

#1	3:00 p.m.	#6	5:25 p.m.
#2	3:25 p.m.	#7	5:50 p.m.
#3	3:50 p.m.	#8	6:20 p.m.
#4	4:20 p.m.	#9	6:45 p.m.
#5	5:00 p.m.	#10	7:15 p.m.

* Interviews were conducted on 12/31/97.

Table #3 Interview Results

Survey Questions/ Informants	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10
HIV Knowledge										
Complete knowledge *						.	.			
Partial knowledge **
No knowledge ***		.		.					.	
AIDS Knowledge										
Complete knowledge *			
Partial knowledge **										
No knowledge ***
Modes of Transmission										
Complete knowledge *					.	.	.			
Partial knowledge **
No knowledge ***										
Source of Information										

School	.	.	.		.		.	.
Workplace		.								.
Hospitals				.					.	
Conversations with people										.
Media	.		.	.	.	.	.		.	.
Transfer Info. Socially										
HIV/AIDS is discussed with friends			.	.			.	.	.	.
Topics Discussed:										
- modes of transmission				.			.	.		
- impact on Black people							.		.	
- providing support for someone infected								.		.
- prevention practices			.				.	.	.
HIV/AIDS is not discussed with friends	.	.			.	.
Impact of Racism										
Reported Impact			.						.	
In the area(s) of:										
- data reporting			.							
- access to services for HIV + African Americans									.	
No reported impact	.	.		.	.	.	.	.	.	.
Awareness of the Tuskegee Syphilis Study										
Reported Awareness	.		.		.		.		.	.
No Reported Awareness		.		.		.		.
Impact of the Tuskegee Syphilis Study										
Reported impact			.		.		.		.	.
In the area(s) of:										
- limited information for the study and HIV/AIDS										.
- AIDS also began as an experiment, created to destroy certain communities			.				.			
- the use experimental drugs for HIV									.	
- Increase your awareness					.					
No Reported Impact	.									
Not Applicable		.		.		.		.
Suggestions to Increase										

Knowledge										
Increased Education			•			•	•	•		•
- in school	•				•				•	
- the workplace				•						
More Surveys			•							
More on television									•	
Info. On cereal boxes										•
Condom Distribution							•			
Community Intervention			•				•	•		
Personal Responsibility		•								
Discussing HIV/AIDS	•			•	•				•	•
Practice Monogamy		•								

* Complete knowledge = the informant was completely knowledgeable about the subject matter.

** Partial knowledge = the informant had some information about the subject matter.

*** No knowledge = the informant responded but the information was incorrect.

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Racism and HIV/AIDS among African Americans: Dismantling One Addresses the Other

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PIM 55

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