

5618

MINORITY HIV/AIDS PROGRAMS
COMMUNITY-BASED ORGANIZATION EVALUATION

HIV/AIDS EDUCATION/PREVENTION GRANT PROGRAM
1988-I 989

A CROSS-SITE EVALUATION

FINAL REPORT

for the

OFFICE OF THE ASSISTANT SECRETARY OF HEALTH
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF MINORITY HEALTH

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Contract No. 0353-94-2-00013

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ACKNOWLEDGEMENTS

This HIV/AIDS Education/Prevention Grant Program Evaluation Study was funded by and prepared for the Office of Minority Health (OMH), Department of Health and Human Services. It was carried out by Tonya, Inc. under contract No. 0353-94-2-00013. Tonya, Inc. is a Small Business Administration 8 (a) certified firm that has provided services to commercial and federal clients since 1979.

Our deepest appreciation goes to the project staff, field guides, and community residents who collaborated with the study team at the two pre-tests and nine project sites visited. Their genuine hospitality, openness, and dedicated service to their respective communities are most impressive and appreciated.

The historical context of the OMH HIV/AIDS Education/Prevention Grant Program provided by Georgia Buggs, Interim Director of Community Demonstrations and Assistance, was very useful. We extend our thanks to John H. Walker III, Acting Director, OMH HIV/AIDS Programs and the OMH Project Officer for his flexible management style and allowing the study team to make design adjustments as necessary. This kind of guidance and support was much appreciated by the Tonya, Inc. management and project staff.

The active participation of the Advisory Committee members, whose names appear in Appendix A, greatly helped to fine tune the evaluation design and other technical aspects of the study. Special thanks are extended to Tonya, Inc.'s team of consultants for their technical expertise, cross-cultural sensitivity, and complementary research skills which contributed to the successful completion of this contract. They are Charles C. Cheney, Edward C. Green, Benardine M. Lacey, and Jacqueline M. Smith.

Finally, we acknowledge with thanks, the contributions of those individuals who provided the administrative and behind-the-scene technical support required to meet contract obligations and deliverables, namely, Shelly Posniewski, OMH Contract Office; Daisy Garcia, OMH staff; and Anne Brown Rodgers, editor.

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EXECUTIVE SUMMARY

Introduction

In recognition of the devastating and disproportionate impact of AIDS on minority communities, Congress appropriated funds in Fiscal Year 1988 for the Office of Minority Health (OMH) to address HIV/AIDS education and prevention issues in minority communities. OMH was one of the first Federal agencies to provide direct funding to minority community-based organizations in the area of HIV/AIDS education and prevention.

OMH funded 33 community-based organizations (CBOs) (\$50,000 per year average), and 5 minority national organizations (NOs) (\$75,000 per year average) involved in HIV/AIDS education and prevention activities in 1988 and 1989 for a period of three years each. This undertaking represents the first external assessment of the OMH Minority HIV/AIDS Education/Prevention Grant Program.

Study Design

A multiple case study approach was used to assess nine of the 38 projects in terms of unique context, processes, and outcomes while allowing for the comparison of structural and process elements across projects. Selected projects comprised a representative sample of those funded based on the following criteria: race/ethnicity of target population; geographic region; intervention used to reach the target population; and cohort year of funding (1988 or 1989).

In view of this small sample size, it seemed most appropriate that qualitative research methods in the form of rapid assessment procedures (RAPs)¹ be used during two and one-half day site visits. These were comprised of in-depth interviews with available individuals who could provide comprehensive overviews of the projects, small group discussions with project staff, beneficiaries, and community leaders, and direct observation of project activities. These methods were used to assess project accomplishments and provide insights into the sociocultural context and interactional dynamics of each project.

A standardized interview instrument was developed by the study team to collect information from key respondents during site visits. Two projects not included among the study sample were selected for pre-test of the data collection procedures and the interview instrument. Modifications were made based on feedback from pre-test participants. The study team made site visits to the nine projects over a period of four months.

¹ Cheney, C.C., (Ed.), **Rapid, Low-Cost Rapid Assessment Techniques**. Washington, DC: U.S. Agency for International Development, 1991.

The evaluation team sought and received input from an advisory committee and grantees during every phase of the evaluation design and implementation. The advisory committee was composed of four grantees and representatives of three Federal agencies. The study team conducted pre- and post-evaluation grantee/advisory committee meetings in Washington, DC, and one advisory committee meeting half-way through the data collection phase.

Data Analysis Strategy

This study defined four outcome variables by which to measure project performance. These variables were: (1) attainment of project objectives, (2) the degree of influence of the project on local health care providers/system, (3) the number of project functions that continued after OMH funding ended, and (4) the number of unanticipated community benefits. After a preliminary analysis, it was hypothesized that these outcomes depended on nine influencing factors. These factors were:

1. Existence of AIDS-related activities before OMH grant;
2. Project organization linkage to health care-related provider(s) or project linkage to social service agencies;
3. Project programmatic complexity (e.g., education, outreach, referrals, screening, case management, health/medical care, transportation, and translating educational materials and messages for target population);
4. Project population focus (e.g., focusing on a particular behavioral subset of the population, or the total community);
5. Project design to fit the population/community;
6. Community input during formative and implementation stages;
7. Project implementation: flexibility/adaptiveness to contingencies;
 - a. Project implementation: expansion of services; and
9. Role of OMH, including functions, monitoring and oversight, available monies, quality of relationship, and technical assistance offered.

The study's four outcomes were generally measured at the ordinal level with five categories (e.g., none, few, some, most, all). Factors that influenced those outcomes were either measured as naturally occurring dichotomies (e.g., yes, no) or ordinals with three categories (e.g., minimal, moderate, high). Because study variables tended to consist of ordinal measures, the Mann-Whitney-Wilcoxon Rank Sum test was used for statistical testing of relationships (e.g., statistically significant associations of factors influencing outcomes), while Gamma was used to measure the strength or magnitude of statistical associations.

Findings

Attainment of Project Objectives

- All projects were successful in achieving this outcome. Indeed, seven of the nine projects (78 percent) achieved most of their objectives, and two (22 percent) achieved all of their objectives.
- None of the nine influencing factors had a statistically significant relationship with attainment of project objectives. However, data from all sources suggest that the commitment and dedication of project staff may explain why projects achieved, and in some cases exceeded, their stated objectives.

Influence on Local Health Care and Other Social Service Systems

- Projects that were designed to fit the population/community were more likely to have a relatively high level of influence when compared to other study variables, such as population focus, programmatic complexity, and community input.
- When projects established and maintained linkages with other social service facilities, either through project staff or advisory board members, their projects were more likely to be involved in local decision-making processes about HIV/AIDS services.

Continuation of Project Functions

- Both the existence of AIDS-related activities before OMH funding and the degree to which a project was designed to fit the population/community had statistically significant relationships to the continuation of functions post-OMH funding.
- Projects that limited their focus to behavioral subsets of the population at risk, rather than the total community, tended to continue to perform relatively more functions in the post-OMH period.
- Somewhat surprisingly, linkages with the local system of health care providers had very little effect on the continuation of activities post-OMH funding. Linkages with the local system of health care providers are desirable in terms of sharing resources and non-duplication of services, but if an organization is providing a service no one else is providing, continuation may not be contingent upon linkages made with the local system.

Generation of Unanticipated Community Benefits

- All projects generated “unanticipated” benefits to individuals and communities. Indeed, to their credit and ingenuity, most projects (55 percent) exceeded the objectives stated in their proposal to OMH.
- The two factors that demonstrated a statistically significant relationship to the generation of unanticipated community benefits included (a) an organization’s prior participation in AIDS-related activities, and (b) the fit of the project’s design to the population/community.

Key General Observations

- Seven of the nine projects selected for this evaluation are still active. In all cases, HIV/AIDS education/prevention programs have been integrated into on-going services, either at the CBO, or into other public forums, e.g., court system, penal institutions, gay bars.
- Most projects indicated the need, or were in the process of establishing, staff support mechanisms to process job-related and personal grief and stress resulting from intense and sustained involvement with people infected with or affected by HIV/AIDS.
- Seven of the nine projects that targeted adults or the general population have recognized the need to develop special programs for youth.
- Staff members from at least two projects were singled out and ostracized by either family or community members for conducting HIV/AIDS-related outreach and education. In all cases, staff members resisted this kind of pressure and continued with their activities.
- Five of the nine projects experienced some form of interorganizational “turf battle” while involved in conducting HIV/AIDS education and prevention services. None of the projects has received (in the past or currently) the funding from local, state, and Federal resources that they need to address HIV/AIDS education and prevention issues among their target population.
- OMH had minimal contact with projects after they received funding. The projects relied primarily on local experts and their own resources to address process, implementation, and evaluation issues.

- Many institutional barriers still exist, especially at the state level, for minority people in general, but specifically with regard to gaining access to HIV/AIDS funding. Strategies for improving minority involvement in decision-making process remain a challenge.

Conclusions

The conclusions that follow are based on an analysis of data from all sources including observations made by the evaluation team during site visits.

1. The projects under review achieved all (two projects) or most (seven projects) of their objectives.
2. OMH direct funding made it possible for essential HIV/AIDS education and prevention services to be provided in racial/ethnic minority communities. However, OMH had limited resources during the period under review to monitor projects and provide the technical assistance desired by these demonstration projects.
3. A common characteristic of all nine projects was an intense and sincere commitment of project staff to achieving project goals, and a willingness to contribute extra time and personal resources to meet the needs of the target populations.
4. CBO HIV/AIDS education/prevention projects that have a specific population focus, strong linkages to social services, and offer a broad range of related HIV/AIDS services — either directly or indirectly — are more likely to achieve many of their program objectives.
5. Projects that consistently demonstrate effectiveness in reaching their target communities are more likely to influence health care providers and other social service agencies.
6. Projects that were engaged in HIV/AIDS programs before the OMH grant were more likely to continue HIV/AIDS program activities after OMH funding ended.
7. More program development resources are needed to address other complex issues related to HIV/AIDS particularly (1) sexually transmitted diseases (STDs) and their effects among youth as well as (2) the impact of alcohol and other drugs and how they put individuals and families at risk for HIV/AIDS and other STDs.
8. Racial/ethnic minority CBOs are not receiving available HIV/AIDS funding and support from local, state, and Federal sources in proportion to the prevalence or potential impact of the disease in their communities.

Recommendations

The recommendations that follow are based on the study's conclusions as well as the collective viewpoints of the evaluation team and grantees. The use of a strong imperative in stating most of the recommendations is not meant to be provocative. It honors a commitment to the grantees to reflect their contributions and suggestions at the post-evaluation grantees/advisory committee conference.

A. Recommendations for Projects

1. **CBOs** must determine where HIV/AIDS education/prevention gaps exist in their communities. To the degree possible, **CBOs** should form viable linkages with community-based health provider entities and social service agencies in order to provide coordinated and comprehensive HIV/AIDS health services in the community.
2. Projects should incorporate AIDS-related activities that existed before Federal funding into the conceptualization and implementation of the project. Projects that build upon existing AIDS activities may be better able to influence the local health care and social service agencies, and are more likely to continue after Federal funding ends.
3. Projects must conduct and document internal formative/process evaluation. This will lead to the early identification and resolution of educational barriers and constraints, strengthening of the project's responsiveness to changing needs, and provide a data base to demonstrate effectiveness and attract resources to sustain the project.
4. **CBOs** should actively seek required technical assistance from all available sources as the need arises. Appropriate and timely technical assistance contributes to staff capacity building and project effectiveness.
5. Racial/ethnic minority **CBOs** must take the initiative to ensure meaningful representation in the current Centers for Disease Control and Prevention (CDC)-sponsored HIV Prevention Community Planning Process (PCPP), e.g., organize local racial/ethnic minority CBO HIV/AIDS Councils to elect representatives for the PCPP; identify representatives of the councils to serve on subcommittees or regional committees organized by PCPP; communicate frequently with elected officials; and make suggestions to the CDC program officer assigned to their respective region/city/project.
6. **CBOs** should fully utilize the OMH Resource Center services that can assist in carrying out project objectives. In turn, **CBOs** should provide the OMH Resource Center with information and materials of potential interest and utility to

other projects and Federal agencies. The OMH Resource Center's toll-free number is: 1-800-444-6472.

B. Recommendations for Federal Funding Agencies

1. Federal funding agencies seeking to have local impact in HIV/AIDS risk-reduction/prevention must give priority to funding community-based organizations that have demonstrated effectiveness in meeting community needs.
2. The awarding of grants to health provider organizations to carry out HIV/AIDS risk-reduction/prevention efforts should be made contingent upon demonstrated evidence of the active role of **CBOs** as representatives of their communities in all programmatic decision-making processes.
3. In light of the demonstrated effectiveness of directly-funded programs, Federal funding agencies must continue their commitment to providing grants directly to deserving **CBOs**, in addition to addressing local needs through **community-based** partnership.
4. Funding guidelines must specify the requirements for conducting and documenting internal formative/process evaluation in all such projects. This would provide Federal agencies with the information they require to better target limited funds in the future.
5. The Request for Proposal (RFP) should also specify that by accepting a Federal grant, recipients agree to participate in Federal agency-sponsored external evaluations.
6. In order to establish a continuity of relationship to grantees, Federal agencies must monitor projects through site visits, response to periodic reports, and maintain on-going communication throughout the project period. Consideration should be given to using the Centers for Disease Control Cooperative Agreement model.
7. Federal agencies must assist with defining, providing, and referring **CBOs** to sources of technical assistance (TA) as needed throughout the grant period. This can be done through site visits, regular grantees meetings, written and telephone communication.
8. OMH must continue to assist racial/ethnic minority communities in the following ways: (a) provide information about Federal funding opportunities; **(b) continue** its role as advocate for racial/ethnic minority populations within the Federal government; and (c) broaden the OMH Resource Center functions to include

solicitation of effective educational and training materials developed by grantees, and the reproduction and distribution of these materials (including bilingual editions) on a regular basis.

9. Projects must be made aware of the benefits of evaluation. Federal funding agencies must set aside monies for and inform grantees of available technical assistance for evaluation in the RFP.
10. The OMH Resource Center must organize a data base of examples of specific materials commonly used (e.g., needs assessment instruments, evaluation tools, confidentiality statements) by OMH grantees (past and present) and other racial/ethnic minority CBO's.

C. Recommendations for Future Research

1. Assess the strength of the relationship/association of project planning, implementation and outcomes with the nine influencing factors in a larger sample of CBO HIV/AIDS education/prevention projects.
2. Identify key influencing factors that determine the similarities and differences of racial/ethnic CBO HIV/AIDS education/prevention projects in rural areas. Determine if they are different from those that are associated with effective urban CBO HIV/AIDS projects.
3. Examine the competitive grant process and, its impact upon collaboration among organizations in the same geographical area.
4. Examine agency management practices at the Federal level and how they affect relationships with CBO grantees.

I. Introduction

As part of its mandate to address the historical disparity in the health status of racial/ethnic minority populations compared to non-minorities in the United States, the Office of Minority Health, awarded grants to community-based organizations to develop health initiatives that would have an effective and positive impact on the health risk factors of Asian Americans, African Americans, Hispanics, and Native Americans in the United States. These population groups adversely suffer from the six health problem areas detailed in the August 1985 *Report of the Secretary's Task Force Report on Black & Minority Health*.

In October 1990, the Disadvantaged Minority Health Improvement Act required the OMH to evaluate and disseminate the findings on projects funded with OMH assistance and resources.

HIV/AIDS Education/Prevention Grant Program

In 1988, AIDS was added to the list of six priority health problems of minority communities identified in the 1985 *Report of the Secretary's Task Force on Black & Minority Health*. Because of the devastating and disproportionate impact of AIDS on racial/ethnic minority communities, AIDS was added as the seventh priority health problem and Congress appropriated funds in Fiscal Year 1988 for OMH to address the issues of HIV/AIDS in racial/ethnic minority communities. OMH was one of the first Federal agencies to provide direct funding to community-based organizations through its HIV/AIDS Education/Prevention Grant Program. OMH provided 3-year HIV/AIDS education/prevention grants to racial/ethnic CBO's. These grants, which began in 1988, were awarded to 33 CBOs and five minority national organizations (NOs).

The first director of the HIV/AIDS Education/Prevention Grant Program served from 1988 to 1989. During an interim period in 1989, two consultants were hired by OMH to carry out project site visits and offer as-needed technical assistance. Following that period, the OMH appointed a second director, who served from 1989 until 1992. In 1992, OMH appointed an acting program director for the program. During their tenure, project directors had limited support staff and were responsible for providing technical assistance and project monitoring. These responsibilities became increasingly demanding as the number and complexity of projects increased over the years. Subsequent reorganization of the office and change in project support procedures have improved monitoring procedures of projects.

II. Study Design and Procedures

This is the first effort to evaluate the HIV/AIDS Education/Prevention Grant Program since its establishment in 1988. A number of challenges were overcome in order to conduct this retrospective study, including project personnel changes during and after OMH funding, incomplete OMH files of periodic and final reports, limitations on the number of individuals who could be interviewed at a given site, varying racial/ethnic minority populations and types of interventions, a two- to three-year lag time between the end of the project and the evaluation, and a small allowable sample size — nine out of a universe of 38 projects — for the evaluation study.

Similar kinds of challenges and the reasons for their prevalence are described by Susan L. Coyle, et al., in Evaluating AIDS Prevention Programs². Dr. Coyle pointed out that evaluating community-based HIV/AIDS health education prevention projects presents both conceptual and practical problems that are quite different from those that are encountered in evaluating an HIV/AIDS media campaign or a testing and counseling program. The major conceptual difficulty arises from the diversity of interventions and constituent groups served by projects. The major practical difficulty is the scarcity of comprehensive information available about or from individual projects. Given the small size of grants (\$50,000 per year for three years) and their emphasis on education and prevention, community-based projects have not paid much attention to the development and maintenance of management information systems, monitoring, or evaluation. Further, CBO project personnel tend not to have the technical training and experience in evaluation.

A. Purpose

The primary purposes of this evaluation were to:

1. Produce an assessment on the effectiveness of completed projects funded in 1988 and 1989 under the OMH Minority HIV/AIDS Education/Prevention Grant Program; and
2. Assess the projects' value to and impact on OMH in addressing HIV/AIDS issues on behalf of racial/ethnic minority communities,

Evaluation objectives were to assess five specific areas: (1) organizational and implementation processes; (2) effects (positive and negative) of project interventions; (3) overall project accomplishments, unanticipated outcomes, and needs; (4) lessons learned; and (5) effects of projects on OMH policy and administration. The final objective was (6) to formulate two-fold recommendations to help the projects

² Coyle, Susan L., et al (Eds.) **Evaluating AIDS Prevention Programs, Expanded Edition**, National Research Council, National Academy Press, Washington, DC, 1991.

undertake more effective HIV/AIDS education/prevention programs and to assist Federal agencies in designing effective grant programs.

The TI Team used a qualitative case study approach in conducting a retrospective evaluation of a representative selection of nine of the 38 projects funded under the OMH HIV/AIDS Grant program in 1988 and 1989. It should be noted that these projects sought to develop and implement health education approaches to stem the ravages of the HIV/AIDS epidemic in their communities within the constraints of limited funds and a three-year grant period. Therefore, an attempt to evaluate the projects' results in terms of their influence on community behavior change, much less the improvement of health status, would not have been realistic or productive. More revealing and relevant would be the identification of factors that seem, in combination, to account for four specific positive project outcomes across project sites: 1) the attainment of project objectives; 2) the degree of influence of the project on local health care providers/system; 3) the continuation of project activities beyond the grant period; and 4) the generation of any unanticipated community benefits that occurred as a result of the projects' efforts.

Two types of grantees received OMH awards in 1988 and 1989: community-based organizations and national organizations. The national organizations were asked to identify affiliate CBOs/chapters within 50 miles of their office as well as the number of years each CBO received support from them. Both were planned to be proportionally represented among the nine selected projects. However, the two national organizations initially represented in the sample of nine projects declined to participate in an evaluation of their nearby CBO affiliates. CBOs represented 87 percent of all grantees, and so this study focused on a thorough assessment of the subset of CBOs for actual site visits.

B. Design

The scope of work for this evaluation prescribed that only nine of 38 projects funded during the period under review would be selected to participate in this evaluation. Projects selected for site visit made up a representative sample of projects funded based on the following criteria: race/ethnicity of target population; geographic region; intervention used to reach the target population; and cohort year of funding (1988 or 1989). After the Project Officer and TI Team agreed on the initial selection, three projects declined to participate in the study. The TI Team consulted with the Project Officer and recommended three alternate projects that most closely reflected those that were originally selected. The Project Officer approved the list of alternate projects.

A multiple case study approach was used to examine each project's unique context, processes, and outcomes while allowing for the comparison of structural and process

elements across projects.³ In view of this small sample size, it seemed most appropriate that qualitative research methods in the form of rapid assessment procedures (RAPs) be used. For example, an in-depth interview with the available individual who could provide a comprehensive overview of the project; small group discussions with project staff, beneficiaries, and community leaders; and direct observation of project activities were designed to assess project accomplishments and provide insights into the sociocultural context and interactional dynamics of each project.^{4 5}

A standardized interview instrument was developed by the study team in order to collect information from one key informant interview per site with the available individual who was most knowledgeable about each respective project. Two projects were first selected for a pre-test of the data collection procedures and the interview instrument. During the one-day pre-test visit at two locations, former project staff and beneficiaries reviewed the study team's methodology and provided initial insights, and make suggestions for modifying and improving the interview instrument and evaluation procedures.

An important conclusion of the pre-test was that it was necessary to interview more than one individual with knowledge of the project in order to obtain a comprehensive picture of project activities and accomplishments. Therefore, procedures were modified so as to interview several informants, when available, and to conduct focus groups of key categories of participants. The pre-test also revealed that transportation reimbursement for community participants and honoraria for the individuals who escorted the TI Team during each site visit ("field guides") were important incentives for getting participation from persons who were no longer involved in the program. It also represented a change from the usual take-from-but-don't-give-anything-back approach to external evaluations.

The data analysis plan involved the examination of all collected documentary information and of site visit data on the nine projects. For analysis, the study team used cross-tabulation procedures in order to draw tentative conclusions about relationships of project characteristics with project outcomes across all nine sites. Due to the small sample size and the purposive sampling procedures, statistical tests such as chi square were inappropriate. The within- and across-project analysis performed

³ Yin, R.K. **Case Study Research: Design and Methods**. Newbury Park, CA: Sage Publications, 1984.

⁴ Cheney, C.C. (Ed.) **Rapid, Low-Cost Rapid Assessment Techniques**. Washington, D.C.: U.S. Agency for International Development, 1991.

⁵ Green, E.C., "A Consumer Intercept Study of Oral Contraceptive Uses in the Dominican Republic." Studies in Family Planning, Volume 19, No. 2, pp. 109-117, 1988.

on the project data sought to determine those factors and combinations of factors most important for a range of project outcomes, including the achievement of objectives, continuation of activities, community impact, and community benefits.

C. Procedures

The information collection plan focused on the gathering of data through the review of OMH documents pertaining to the nine projects in the study, including: information presented by representatives of the nine projects at the national meeting of the project advisory group held in Washington, D.C. on January 27, 1994; and on data gathered during the conduct of site visits to the nine projects by a two-member team (TI's Project Director and Deputy Project Director) over a four-month period. Before each visit, a profile of each project was constructed from available secondary documentation. The TI Team sought to gain as much information as possible about each project before the site visit in order to reduce the burden on respondents and CBO staff.

The TI Team used a local field guide selected by the Project Director from two nominees proposed by the grantee. One field guide each at seven sites and two field guides at two sites assisted the team with community *entré* and provided valuable information about the local context of the project and about current AIDS-related services available in their respective communities. The average site visit lasted two and one-half days. Each visit included direct observation (where applicable) of intervention processes, as well as individual and group interviews with program staff, community participants, and other relevant project participants (e.g., Board members). Adjustments were made to accommodate the specific schedules of personnel at each project site.

The interview instrument was used to conduct one key informant interview per site with the available individual who was most knowledgeable about the respective project. It was recognized that the project director may not always be accessible or available to the TI Team for various reasons such as changes in employment, etc ,so the evaluation team used flexibility in its approach at each site depending on the given circumstances. For example, the TI Team interviewed a former project director who had moved to another state while on another site visit to that state.

Other site interviews included small group discussions and individual, non-structured conversations with past and current clients. Every effort was made to ensure that the site visits were as non-disruptive to current project functions as possible. The TI Team made efforts to minimize the amount of time required of project staff to answer questions, and to use measures that ensured that the TI Team was unobtrusive and attuned to the concerns of the project beneficiaries and the community. A generic site visit itinerary is shown below:

Day 1: (Day after arrival)

- Meet with project administration staff for: 1) briefing on the goals and objectives of the study, (2) review of current status of the project and the draft profile, (3) minor adjustments to the site visit schedule,
- Meet with field guide for briefing and agreement on scope of work,
- Gain orientation to the target community from key contact person and field guide.
- Tour of the target community and local health care facilities with field guide.

Day 2:

- Conduct interview with key informants and contact volunteers and/or project beneficiaries where possible (3-6 people).
- Observe on-going activities or other intervention efforts (e.g., support group sessions, presentations, or other group activities).

Day 3:

- TI Team oral presentation of preliminary site visit impressions to staff and field guide and open discussion.
- TI Team afternoon departure.

Field guides were given an honorarium for providing assistance; transportation reimbursement was provided for individuals who participated in interviews at nine sites; and each project was given a small honorarium to defray expenses related to preparing for the site visit. The study team was well-received at each site, and the team followed up with a letter of appreciation to project hosts. Within three weeks after each visit, the Study Team constructed a draft case study and sent it to project staff with requests for editing and clarification of information gathered (see Section III). The TI Team then analyzed the aggregate multi-case data (see Section IV), and developed preliminary conclusions and recommendations (see Section V).

Pursuant to objective number six of the evaluation, the evaluation team interviewed the second OMH HIV/AIDS Education/Prevention Grant program director. The first left OMH in 1989, is no longer in the Washington DC area, and, therefore, was not available to the evaluation team for an interview.

D. Roles of the Advisory Committee and Grantees

Under OMH guidance, seven professionals were assembled as the evaluation's Advisory Committee (AC) at the outset of the study. The members were selected from the pool of former HIV/AIDS grantees (four representatives) and Federal agencies (three representatives). The AC was organized to provide guidance to the study in the areas of research design, information gathering, and interpretation of findings based on members' first-hand knowledge of minority populations, HIV/AIDS service delivery, and programmatic approaches addressing the issue of HIV/AIDS and related minority health issues.

The AC received draft copies of all study documents, protocols, and instruments for review and comments before their use by the study team. The AC gave direct feedback through three meetings during the course of the study.

In order to improve the design of the study, a joint AC/grantee meeting was convened on January 27, 1994, to review and critique all aspects of the proposed study, including all information collection techniques, with attention to the interview instrument. Representatives from seven of the nine projects attended the conference, and four of seven AC members were in attendance. Based on the results of the pre-test and the joint grantee/AC meeting feedback, the instrument was edited to eliminate redundancies, enhance clarity, improve "flow," and reduce length and respondent time burden. Additional feedback given at the January meeting suggested that the study team use an informed consent document during the information collection phase to ensure confidentiality to the respondents. One was developed, however, none of the interviewees were either minors or expressed concern about confidentiality.

After the TI Team completed the nine site visits, it convened an AC meeting on July 22, 1994, in Washington, DC to review collected data and to receive feedback on the data analysis plan. Simultaneously, draft case studies were sent to each site-visited grantee for correction of facts and comments before the analysis phase of the study, and copies were distributed to the AC on July 22, 1994.

A draft of the final report was sent to the AC members and grantees for feedback and comments before completion of the final report. A final joint meeting of the AC members and- grantees was held on September 14, 1994, in Washington, DC, to present preliminary study findings and to refine recommendations made by the study team. Further refinement of the final report resulted from these proceedings, and the TI Team incorporated grantee and AC recommendations into the final report.

This meeting was held the day before and at the same venue as the National Congress on the State of HIV/AIDS in Racial/Ethnic Communities and provided an opportunity for participation in the Congress. Grantee's attendance at the Congress served two purposes: (1) to address needs they identified during the evaluation,

including technical assistance and networking; and (2) to strengthen the recommendations in the final report based on new information grantees obtained from their participation in the Congress.

The original contract was modified in order to make the two meetings described above possible. No additional funds were required because of effective management of the budget throughout the contract period.

It should be noted that the TI Team actively pursued and maintained a process of continuous communication with grantees and AC members for maximum participation in all aspects of the evaluation and feedback on all products produced.

III. Findings

A. OMH HIV/AIDS Program

Program Effects on OMH Policy

OMH feels that the initial HIV/AIDS grants were instrumental in helping minority CBOs to build their capacity to identify and address HIV/AIDS problems in specific racial/ethnic minority communities. A critical mass of minority CBOs is now able to participate in HIV/AIDS program planning and decision-making in their respective communities.

Presently, OMH funds for HIV/AIDS are channeled through Interagency Agreements with two HRSA programs: the Office of Rural Health Policy, and the Bureau of Primary Health Care. The latter is specifically designed to establish Minority Community Health (MCHC) Coalition HIV/AIDS-centered programs for residents of public housing. The present HIV/AIDS project officer maintains contact with existing projects as co-project officer with HRSA, which has the primary responsibility for project monitoring.

Successful HIV/AIDS grant applicants are now required to form coalitions to broaden community involvement. At least 51 percent of member organizations or individuals of the governing boards of these coalitions must represent or be a racial/ethnic minority population. These changes have been made in part because of lessons learned from an evaluation of OMH's Coalition Demonstration Grant Projects completed in 1993.⁶

Major Challenges

The major challenges during the period under review and identified by a former HIV/AIDS Project Director were: (1) the large number of projects (38), (2) the inexperience of most CBOs in managing Federal grants and thus requiring more attention than was possible with limited support staff, and (3) the lack of sufficient support, experience, and funds for CBOs who struggled with the attitude that HIV/AIDS was a problem only in the gay community.

A new challenge that racial/ethnic minority CBOs currently face is how to ensure meaningful representation and participation in the community partnership planning process, recently mandated by the Centers for Disease Control and Prevention (CDC),

⁶ Tonya, Inc., **Minority Community Health Coalition Demonstration Grant Program (1986-1989) Multiple Case Study**, Volumes I and II, Office of Minority Health, Department of Health and Human Services, Washington, DC, 1993.

as a condition for states to receive Federal grants for HIV/AIDS education and prevention programs.

Technical Assistance

Technical assistance (TA) was provided to potential applicants through preapplication regional workshops. After CBOs were funded, the appointed Project Director attempted to visit all projects within the first few months of funding to review project goals and objectives, and observe project start-up procedures. Thereafter, site visits were made when possible, and TA was provided when a specific problem was identified by the grantee, or at the request of the grantee during the life of the project. Although OMH held annual grantee meetings to provide a forum where TA could be sought, the major constraint identified by Project Directors in carrying out grants management related to the lack of sufficient staff to provide ongoing TA to projects.

B. Case Studies

This section contains case studies of the nine representative projects that were visited by the study team. Each of these case studies contains the following components: the context (the setting, the minority community, minority community health status), project initiation (antecedents, organization, design), project implementation (program functions and activities, modifications, evaluation components), project outcomes, and project perspectives on lessons learned and suggestions for other projects and OMH.

PROJECTCASESTUDY

Programa de Educacion Sobre el SIDA/AIDS Goleta CA

In 1988, OMH made a three year HIV/AIDS Education/Prevention grant award to the Community Action Commission (CAC) in Goleta, California, to provide bilingual, bicultural AIDS education and information to prevent the spread of the HIV virus in Santa Barbara County's Hispanic population. The project targeted two groups: Hispanic women whose children were enrolled in CAC's Head Start and Child Care Programs, and Hispanic men who work in the ranches, fields, and nurseries in the medically-underserved areas of Santa Barbara County.

I. THE CONTEXT

The Setting

The project targeted Hispanic women through CAC's Head Start/Day Care program and Hispanic men who worked in the service industry in Santa Barbara County — people working in restaurants, hotels, private homes, or in the ranches, fields and nurseries. Most were undocumented workers with little formal education, although some were bilingual in Spanish and English.

CAC and the county AIDS Service sought the opportunity to expand their AIDS education efforts for minority people in Santa Barbara County, based on local and national statistics, and the dearth of bicultural and bilingual AIDS educators and information available. This project was a partnership with the Santa Barbara Community Clinic Association (SBCCA). Although involved in AIDS work since the first case was diagnosed in Santa Barbara County in 1983, SBCCA was seeking to expand both its medical services and outreach/education efforts to low-income and minority populations in the communities of Santa Barbara and Guadalupe.

The project had a county-wide scope, but the media/information campaign specifically focused on the populations of Lompoc, Santa Ynez Valley, and Carpenteria, where there was no AIDS outreach and education being done. Santa Barbara County is 30 percent Hispanic, not including migrant farmworkers. All of the target population was low income, and many lived and worked under sub-standard conditions. While the overall poverty level for the County in 1988 was 10.6 percent, 15 percent of Hispanics lived below the poverty level. Analysis of AIDS cases in June 1988 by income indicated that over 90 percent had been Medi-Cal eligible, low-income, or had inadequate or non-existent health insurance.

Health Status

According to 1988 estimates, Hispanics represent seven percent of the population in the United States, but 14 percent of the people with AIDS. Santa Barbara County statistics in June 1988 indicated 103 cumulative cases of AIDS. Cases by race indicated 12 percent Hispanic, three percent Black, and 85 percent Anglo. Estimates of total number of persons with AIDS, AIDS-Related Complex (ARC), and HIV infection in Santa Barbara County estimated 500 to 1,000 cases of ARC and 5,000 to 10,000 cases of HIV infection in the county at that time.

There appear to be internal and external barriers to Hispanics recognizing that AIDS is a problem. Internally (within the Hispanic culture), there has been a reluctance to believe that AIDS affects Hispanics. Additionally, AIDS brings up issues that are rarely discussed together in Hispanic culture: homosexuality/bisexuality, prostitution, injection drug use (IDU), contraception, religion, and death. AIDS education up to that point had not been sensitive to these issues. External (mainstream ideas and/or services) barriers were that AIDS information was often not disseminated in Spanish and/or translations were inaccurate; that health care providers, AIDS educators, and testers were rarely bicultural and/or bilingual; and that significant portions of the county with high Hispanic populations were not served by AIDS education or outreach.

At the time of the grant application, the county was served by the Santa Barbara County AIDS Service, a division of the County Public Health Department (SBCHD). The SBCHD ran five free, anonymous HIV test sites and a speakers' bureau with volunteers to give AIDS presentations. Projects with the County AIDS Service were in place and included: conferences for caregivers; small group meetings for gay men; seminars; training sessions; discussion programs for substance abusers; outreach to drug treatment programs and youth; and education services at the county jail. However, only one bicultural, bilingual educator was available, and his position was cut to half-time. In general, it was thought that more bicultural, bilingual services should be made available.

In San Luis Obispo County, outreach targeting Hispanic migrant farm workers was provided only to a small section of Santa Barbara County. The Santa Barbara County Clinic Association (SBCCA), which provided medical services for low-income people including AIDS and ARC patients, did some outreach to the Hispanic community, but not in the areas with high concentrations of Hispanics.

II. PROJECT INITIATION

Antecedents

The Community Action Commission (CAC) is a county-wide agency governed by a community board comprised of representatives from the public sector, private sector,

and low-income population. CAC's mission is to respond to the needs of low-income and minority residents, and to develop programs and services to meet those needs. Advisory board meetings were held bi-monthly during the project period, and remained active in decision-making for the program throughout the project period. Twenty percent of the board is Hispanic. Thirty percent of the 200+ staff is Hispanic, and the Head Start and Day Care Program is staffed by over 60% Hispanic persons. Before the OMH grant, CAC worked primarily with low-income and minority people in Santa Barbara County for 25 years. Over 50% of CAC's clients are minority, about 85% Hispanic.

CAC consulted with and planned coordination of effort with SBCHD, the SBCCA, the Western Addiction Services/Gay Lesbian Resource Center, the Nipomo Medical Clinic, and members of the County AIDS Task Force and the Youth Program of the Central Coast. CAC was to contract directly with SBCCA to provide AIDS trainers for CAC staff and group presentations, and for radio talk shows. CAC planned to publicize an AIDS 1-800 hotline number to the client population by posting it in all of their offices, and by including the telephone number on all its printed literature. SBCCA was to provide all Spanish-language brochures and posters, and CAC planned to cover partial costs for duplicating materials. Additionally, the CAC AIDS project staff participated in the county AIDS Task Force to share information, coordinate services, and avoid duplication of services.

Design

The project's goal was to provide bilingual, bicultural AIDS education and information to Santa Barbara County's Hispanic population to prevent the spread of the AIDS virus. The project focused on two groups: Hispanic women whose children were enrolled in CAC's Head Start and Day Care programs; and Hispanic men who worked in the ranches, fields, and nurseries in certain areas of Santa Barbara County.

This project included a component for providing AIDS training for agency staff who had the most contact with the Hispanic client population through group presentations and home visits to parents. Also it launched a media campaign that involved talk-shows on Spanish radio, public service announcements (PSAs), viewing of Spanish language AIDS videos, the distribution of posters and literature publicizing AIDS information, and the establishment of a bicultural, bilingually-staffed AIDS hotline. The key to this program was having **bicultural/bilingual** staff available to provide education and training to the county's Hispanic population. The program director and most staff working with clients were bicultural and bilingual. CAC planned to use SBCCA trainers to train staff, evaluate the training component, and meet with the radio show facilitator to produce six radio shows per year. Program Coordinators for social services/parent involvement, health/mental health, and advocacy programs of CAC were to transfer information to their clients once they were trained to provide AIDS information.

Project Objectives

Project objectives were:

1. To provide four bicultural, bilingual AIDS education and information trainings per year to 50 CAC staff in the Head Start/Day Care and Advocacy programs.
2. To make 12 AIDS education presentations per year, drawing from a pool of 500 Head Start and Day Care parent groups using bicultural, bilingual speakers, and videos.
3. To distribute Head Start Family Services AIDS brochures and information on a local Spanish language AIDS hotline to 290 Head Start parents a year.
4. To show Spanish language AIDS videos in the waiting areas of three CAC offices serving predominantly Spanish-speaking clients.
5. To make available free Spanish language AIDS videos in four to six Hispanic video stores around the county.
6. To air six Spanish-speaking AIDS talk shows per year featuring a health educator and community member on Spanish radio stations.
7. To run 1,000 PSA's a year on three Spanish radio stations providing AIDS facts for Hispanics, including locations of free, anonymous HIV test sites, and the existence of a local I-800 Spanish language AIDS information hotline.
8. To distribute bilingual AIDS brochures advertising the AIDS hotline to 6,000 Hispanic persons who receive food through the monthly food distribution program.

Cultural Appropriateness

CAC felt that with the majority of their staff being Hispanic women, it would be appropriate to have them give presentations to parents in the Head Start and Day Care programs. CAC's experience showed that because women in Hispanic culture are responsible for the family's health and education, parents often trust or confide in female staff and are likely to respond to information from those individuals. -It was thought that an intervention strategy using women educators from Head Start staff would work in informing parents about HIV and AIDS. It also helped that the staff had

a captive audience, that is, easily accessible throughout the year through the Head Start and Child Care programs.

Radio was an important method of communicating information in the Santa Barbara Hispanic community since most people had radios, listened to the radio often, and may have had low literacy levels. It was agreed that radio communication was an essential and highly effective means of educating the Hispanic population for this project. CAC sought to use this medium in getting the message out to a greater audience.

Evaluation Plan

Process evaluation measures included staff keeping records, logs, and summary reports of activities, as well as requests for information and services during education sessions and on the hotline. Outcome evaluation methods include pre- and post-tests of staff through training and presentations, feedback forms, tracking numbers of calls, materials, and information requests, and evaluating the general responses of staff, parents, and community to presentations and projects. These measures were used to help evaluate the community's changes in knowledge and to increase the community's interest in and concern about AIDS.

III. PROJECT IMPLEMENTATION

The project was multi-faceted, in that CAC used its community networks and multiple avenues of dissemination to get the message to migrant farmworkers and their families in Santa Barbara County through staff training, worksite outreach, and a mass media campaign.

Staff Training: CAC operated seven Head Start sites and five Day Care centers where it planned to hold group presentations on AIDS to parents. Staff training was provided on a quarterly basis by SBCCA **bilingual/bicultural** AIDS health educators. Training was conducted through a series of presentations with sessions such as "AIDS in the Workplace," and the viewing of Spanish language AIDS videos. During presentations given at the Head Start and Day Care locations, the project used both male and female educators. Given the sociocultural sensitivity to sex-related issues, educators and male and female participants took part in separate gender-specific discussions. When presentations could not find instructors of both genders, the educators encouraged participants to use the 1-800 line so they could ask questions in privacy.

Worksite Outreach: Presentations were also made on the worksites of Hispanic workers at nurseries, in the fields, and in other service jobs sites. The CAC project director drove to migrant worksites in the morning and then asked the field supervisors

for permission to conduct presentations during lunch or "break" time. He established a positive rapport with both the field supervisors and workers, and was flexible in making himself available to them as needed.

Media Campaign: CAC's media campaign was made up of four components: radio talk shows in Spanish on Spanish radio stations giving basic HIV/AIDS information and answering call-in questions; public service announcements advertising the Spanish language AIDS 1-800 hotline and free HIV test sites; free AIDS videos in Spanish available from video stores in Hispanic neighborhoods; and the placement of Spanish and English language AIDS videos in waiting areas of CAC Advocacy offices in Lompoc, Solvang, and Carpinteria. Talk shows were aired free on both radio stations and on a Spanish TV station in Santa Maria. The project was able to contact two local video stores that would lend the AIDS video out for free and keep track of how often it was checked out. One store was in the city of Guadalupe, and the other in Santa Maria. The video was checked out anywhere from once a day to once a week during the project period. The video was made by the AIDS Project of Los Angeles, and was called, "El Examen del Sida - Una Decision Personal." The media campaign slowed down after the first year due to lack of funds available for on-air time. It required some effort to get the radio stations to air spots for free, but the project judged it an extremely important medium for getting the message out.

Educational materials such as posters, brochures, and AIDS literature were distributed to CAC's 30 offices in the county, and also distributed during trainings, presentation home visits, client interviews, and food distributions. After the first year the project began developing a pictorial guide on "How to Use a Condom" to help make the information easily accessible.

Other Services: The project also explored the possibility of giving presentations to the local hospital's housekeeping, food services, and laundry workers. The project performed outreach to Hispanic youth at scheduled presentations in the county, such as the Annual Youth Leadership and Job Fair, a half-way house for Hispanic troubled teens, and through community presentations open to the public. Home visits were also offered to the families throughout the year. Home visits were proposed in order for people to have presentations in a non-threatening environment. For home visits, the project offered to contribute \$10.00 toward food to host families to cover costs. Although some seemed to like this approach, only a few families were willing to host home presentations. Currently, no service agencies offer home visits to provide AIDS information.

CAC had a food distribution program in place at its field office, where it plans to distribute AIDS literature and the AIDS information hotline number. Outreach was done on a one-on-one basis, and people received a 5-10 minute presentation on AIDS and were handed materials while volunteers helped distribute the food. CAC is no longer involved in food distribution at this site due to a shift in funding, although the

service is still perceived to be needed.

Modifications

The project director became involved full-time after the first year in order to accomplish in a timely manner the project's stated goals and objectives. Additionally, because of conflicts in scheduling of trainers and time constraints, it became necessary for the project director to personally conduct most of the AIDS presentations and training. The administrative position on the project was eliminated to accommodate this change. The project director ended up providing most of the direct education to agency staff instead of coordinating with other agencies to conduct the education. The project director also developed the outreach program to better access the Hispanic community by going to worksites (ranches, fields, nurseries) and providing the education there during lunch time, or time that was set aside by the **worksite** field supervisor. The project director's personal commitment to the AIDS education project fostered the dissemination of information to areas beyond the scope of the project goals and objectives, and helped maintain links of communication with other service agencies in the county.

Evaluation for the project occurred mainly through administering pre- and post-tests to the staff and clients. However, these tests did not adequately measure behavior change. Oral reporting from project staff and clients was also used as a measure of the program's effectiveness.

IV. PROJECT OUTCOMES

Achievement of Project Objectives

The goals and objectives for the **Programa de Educacion Sobre el SIDA/AIDS** were accomplished and in some ways exceeded by the end of the OMH grant. The following presentation describes the outcomes of the project objectives:

Objective 1 Outcomes: Twelve culturally sensitive AIDS information training sessions per year to staff took place, each tailored to the specific Head Start and Child Care centers of that community. It was found that education was easier in smaller groups. A total of 13 staff were trained. Field workers reached numbered 505, and the number of advocacy recipients from all **CAC's** offices numbered 7,740.

Objective 2 Outcomes: At least twelve education presentations to parents in Head Start and Child Care took place per year. In the Head Start Program the total number of staff trained was 164, and the number of families reached was 980. In the **Child Care Program**, a total of 98 staff were trained and 330 families were reached.

Objective 3 Outcomes: AIDS brochures and information on a local Spanish language AIDS hotline were distributed to at least 290 Head Start parents per year. Community/ Other Presentations: The project targeted the monolingual Spanish-speaking community through 16 agencies in Santa Barbara County where they did some type of AIDS education outreach. The total number of people reached through these groups numbered 1,453.

Objective 4-7 Outcomes: Spanish-language videos were shown in the waiting areas of four CAC offices serving predominantly Spanish-speaking clients. Spanish-language AIDS videos were made available at only two of six proposed video stores in Santa Barbara County. At least six Spanish speaking AIDS talk shows per year took place featuring a health educator and community member on Spanish-language radio stations. Over 1,000 of these Spanish-language radio PSA's were aired over the project period, giving locations of free, anonymous testing sites, and advertising the 1-800 Spanish language AIDS hotline. Media: Radio/TV Outreach: Total radio talk shows numbered 21, the total number of TV talk shows were two, and the total English and Spanish radio and television PSAs aired during the project were 2,500.

Objective 8 Outcomes: AIDS brochures advertising the AIDS hotline were distributed to 6,000 persons who received food through CAC's monthly food distribution program.

Impact on Providers/System

Service providers interviewed in Santa Barbara County all agreed that the CAC's project served a very important purpose for two reasons: it addressed the Hispanic minority population, and it reached out to migrant campsites in the county. Since the end of the project, no other AIDS service agency has attempted to follow up in conducting on-site intervention despite the fact that all service agencies view it as a very necessary component to AIDS service delivery in migrant communities. The project director for CAC's AIDS education project was an important liaison between AIDS service agencies in the county and the migrant population during the project period. He was able to communicate effectively, be flexible to the needs of the target population (e.g., scheduling presentations at their convenience, being sensitive to issues like sexuality and gender), and he filled a big gap in providing services to the county's migrant population. At the end of the OMH grant period there were no monies at CAC to retain his services, and monies at the county level could not support his position at CAC.

Currently, money for HIV/AIDS from Title II funds and other sources are concentrated at the county level, and the focus on the minority population has diminished. There are now approximately five bilingual and/or bicultural part- or full-time HIV/AIDS educators in Santa Barbara County who work through various service agencies (e.g., Planned Parenthood, community clinics, the County). Although there are now more medical and case management services at the county level for people with AIDS

(PWAs), the focus has shifted away from prevention and advocacy, especially for the minority population in Santa Barbara county.

An inter-agency coalition of government and community-based agencies providing HIV education was established in Santa Barbara County before the OMH grant and continues to exist. Similarly, monthly meetings of the Santa Barbara County AIDS Task Force also take place. These are forums where people have been able to coordinate activities. However, interest and activity has waxed and waned in the past three to five years. It was noted that there is generally little minority representation on organizing committees of this sort in the county.

Project Continuation

CAC is still in existence, but because of a lack of funds for the HIV/AIDS education and outreach component, CAC has discontinued staff training in the Head Start and Day Care curriculum and continuation of field outreach to migrant workers. Despite lack of funding, however, CAC has made efforts to supply general information on HIV/AIDS to staff and clients. The current health education coordinator instructs the staff about AIDS issues, and conducts presentations at CAC's field offices whenever possible. Importantly, it was noted that the attitudes of project staff became more sensitive toward the issues of HIV/AIDS and people with HIV, thereby improving their ability to serve clients.

The media campaign was hard to measure, and from project reports of the number of calls received after a radio or television spot, the response did not seem high. However, when conducting education at client worksites, the staff noted that people did recall the messages of the PSAs to project staff, indicating that people had heard and listened to the PSAs.

Unanticipated Outcomes

- The Head Start program continues to provide AIDS information to staff and clients.
- The project director used his experience at CAC to obtain employment in the Ventura County Alcohol and Drug Program, where he has integrated AIDS training into his alcohol and drug prevention curriculum.

V. LESSONS LEARNED AND RECOMMENDATIONS

Lessons Learned

- The person in charge of health education for the Head Start program should be trained in HIV issues and also be up-to-date on the community resources

available to better serve the client.

- Outreach is desperately needed in Hispanic and African American communities in Santa Barbara County. This would involve an increase in the number of qualified bilingual and bicultural individuals to carry out HIV work.
- Media campaigns are effective in the Hispanic community, especially ones that use local or national Hispanic role models to endorse the issue. Funds are needed to purchase airtime if programs are to be broadcast at peak listening times.
- An important strategy in the next AIDS awareness project to migrant farmworkers would be to seek a higher level of involvement from owners and ranchers.
- The project's advisory committee was critical in decision-making and goal-setting during the project period. Qualities that helped form an effective advisory committee include committed members who have good community networks.
- CAC learned that it was important to be assertive in asking for guidance and/or technical assistance from the granting agency when needed.

Suggestions for Project Improvement

- Urge other Head Start programs in the nation to incorporate HIV education into their curriculum. The use of already existing community service agencies and programs can save a great amount of time and money when providing any type of community education.
- Programs need to document the effect of their outreach programs by statistically tracking the number of referrals or contacts made through the program, how people are using the information, etc.

Suggestions for OMH

- More time and money are needed to carry out and establish grant goals and objectives.
- Community clinics, rather than public health departments, should be funded directly in order to provide AIDS services. Funding should also include enough money to hire more than one person to provide direct intervention and outreach services.

- Services provided by the OMH grant were needed, and succeeded in reaching an underserved population. OMH should continue to fund community-based projects that provide HIV education and intervention. Specifically, OMH should fund projects that address the impact of alcohol and other drug use, and how **STDs** put the individual and family at risk for HIV infection.
- OMH should inform the newly-funded programs of the successes and failures of previously funded programs, especially if there are any similarities among them. This exchange of information should occur fairly early in the grant cycle, probably in the first three months. OMH should respond consistently and offer feedback on project reports throughout the grant period. Technical assistance should be provided throughout the grant period to insure that the program has the best possible chance of continuing to provide services to the community through the use of other funding sources. Toward the end of the grant period, OMH should work with the CBO in identifying resources for funding, or lending technical assistance in that area.
- OMH should mandate ~~that~~ grantees be required to participate in program evaluation efforts, which should be conducted soon after the projects end.

PROJECTCASESTUDY

Outreach, Inc. Minority AIDS Education Project Atlanta GA

In 1988, OMH made a three-year HIV/AIDS Education/Prevention grant award to Outreach, Inc. in Atlanta, Georgia, to implement an AIDS Education and Outreach program using peer educators to reach African American intravenous drug users on the street.

I. THE CONTEXT

The Setting

At the time Outreach, Inc. was formed (1986), there were no AIDS services available for racial/ethnic minorities in the city of Atlanta, much less for substance abusers, especially those using injection drugs. Like many other cities across the country, Atlanta has a significant number of people with drug problems. In 1988 it was reported that close to half of all patients seen with full-blown AIDS were intravenous drug users. But bias in medical care and limited facilities make it difficult to assess the actual number of people infected with the virus in the minority community. This project sought to bridge the gap in services to people of color with the dual affliction of substance abuse and HIV by using education and non-traditional AIDS prevention methods.

Before OMH funded Outreach, the project identified ten neighborhoods as "hard core" drug areas. These areas covered places where people "copped" (obtained), sold, and used drugs. Some areas included street corners, clubs, or housing projects. Outreach conducted visits to these and other areas to assess the need for AIDS prevention, while at the same time distributing bleach, condoms, and literature, and testing the acceptability of bleach from random informal interviews. The so-called "hard-to-reach" population of drug users, Outreach found, could be reached if the proper methods and people were used to reach them. Based on their knowledge of, and access to the injection drug use (IDU) population, Outreach sought to promote the use of bleach to clean drug equipment, to distribute condoms and bleach, and to advance a culturally-appropriate information campaign.

Health Status

Outreach noted national, state, and local health statistics as well as its own experience in assessing the need for an outreach program that addresses the needs of a traditionally-underserved population. Most intravenous drug users only seek medical help when it is extremely necessary. Even then, there are not always facilities or

services available, or they face bias in medical facilities because they are substance abusers. Outreach's application to OMH stated, "it is clear that the minority community has been misled as to who is at risk for contracting the virus." Denial about the virus as well as denial about the effects of substance abuse was pervasive, and awareness about prevention of both was perceived to be low.

As of 1988, there were 14,400 cases of AIDS reported in the State of Georgia, 30% of which were minorities (28% Black and 2% Hispanic). Metropolitan Atlanta had 75% of the total cases of AIDS in the state. Of 146 cases among heterosexual intravenous drug users in Metropolitan Atlanta, 80% were among Black persons, and most heterosexual persons with AIDS and children with AIDS were Black. Although these statistics showed a clear need for intervention in Atlanta's minority communities, the incidence and prevalence of the HIV virus were thought to be grossly underreported by service agencies, because of the dearth of testing and treatment facilities and appropriate medical care.

II. PROJECT INITIATION

Antecedents

Outreach, Inc. was founded in 1986. The organization's mission was to address the need for education and awareness of health issues affecting the minority community and to develop prevention programs around specific health issues. Programs initiated by Outreach in early 1986 were implemented one year later by the State of Georgia, and served as models for the development of the State's Minority AIDS Initiatives Programs. The OMH grant was intended to continue the services Outreach Inc. was performing in the area of AIDS awareness to minorities.

Outreach's founder and current president began AIDS prevention services to Atlanta's African American community in 1986, working out of her car. Her commitment, advocacy, and action led to the establishment of Outreach, which today is a model for other community-based organizations across the country. Because Outreach was the first minority-led and -focused AIDS prevention community-based organization in Georgia, a number of other "firsts" were achieved. Among them, Outreach was the first to: work directly with people with substance abuse addictions and HIV; provide street outreach to the African American community; dispense bleach; host an HIV/AIDS support group in the African American community; offer free and anonymous testing in the African American community; provide free medical transportation for HIV positive people; and place peer counselors in health facilities throughout Atlanta.

Design

In 1987, Outreach was contracted by the state of Georgia through the Morehouse School of Medicine to provide AIDS awareness programs to minority communities

throughout the state of Georgia. The goals of this project were to increase the level of awareness of AIDS, develop a better understanding of the transmission of the virus, and reduce the overall risk of infection throughout minority communities in the state of Georgia. The OMH grant (1988-1991) came at a time when Outreach needed to expand and solidify its efforts in the African American community.

Outreach uses community volunteers, usually persons in recovery from substance abuse for at least three years and/or HIV seropositive individuals, to help carry out their campaigns. Outreach actively recruits people in recovery to be volunteers, paid outreach specialists, van drivers, peer group leaders, and office personnel. People employed by Outreach who themselves are in recovery and/or HIV seropositive are role models for the people they serve. Their success in recovery serves as a positive example for people still using drugs and/or people who are HIV positive. As one Outreach staff member stated, "We came out of that hole, and we can go back in (and help)." Staff at Outreach state that they are, "part of one family."

Each staff member and client at Outreach believes that each and every person involved at Outreach is part of a family which is a caring and supportive unit that fosters acceptance and growth. As one staff member stated, "We will love you until you learn to love yourself." The philosophy of self-help from the twelve-step program of Alcoholics Anonymous is incorporated into coping with people's problems of substance abuse, and their diagnosis with the HIV virus. The twelve-step methodology lends guidance to the structure of support groups and other activities, while the acceptance and care people show each other is the glue that holds Outreach together.

The pride people have in claiming Outreach as their family stems from an organization that is client- and employee-driven, where support groups are peer-led, and where policy and programmatic decision-making are consensual. Clients and staff at Outreach, Inc. state that the organization that belongs to them, and that belief is reflected in the caring and sensitive way they deal with themselves and others. Peer-led support groups are an important mechanism because group leaders mirror and understand clients' feelings and experiences.

Project Goals and Objectives

The goals of the OMH project were to:

1. Provide non-traditional, culturally-sensitive approaches and mechanisms directly to the substance abuser population in an effort to reduce the spread of HIV infection.-
2. Establish a readily accessible system to offer simple information on the modes of transmission of the HIV virus and other pertinent data to

intravenous drug users, their partners, and other affected minorities.

3. Develop a systematic network to provide bleach and condoms to minority intravenous drug users.

Major objectives were to:

1. Identify, recruit, employ, and provide in-depth training to two former intravenous drug users to provide information on AIDS risk and provide bleach packages to 10 major areas in Atlanta where there is a high percentage of drug use. Outreach Specialists were to carry out AIDS prevention in satellite locations (e.g., recreational centers, churches, public housing, rent offices, pool halls) throughout the ten identified hard core drug neighborhoods on a rotational basis to develop working relationships and to gain credibility.
2. Develop or secure easily read pamphlets or brochures explaining AIDS' relationship to intravenous drug use, and a diagram of how to clean "works" with bleach. Provide a package containing bleach, instructions, and other pertinent information, and develop a referral card of treatment facilities throughout the metropolitan Atlanta area.
3. Provide a dedicated telephone line manned by former intravenous drug users to answer inquiries, questions, etc. Advertise the availability of this special telephone number on all distributed literature, posters, and through the local minority media.
4. In the ten identified areas, request cooperation of retail establishments and businesses with significant minority patronage to display AIDS information brochures and posters that emphasize the availability of the special telephone number.
5. Expand the relationship with local health facilities/providers to provide risk reduction information and to continue the joint effort to provide condoms and information to communities at risk. Establish relationships with treatment facilities appropriate for indigent referrals.
6. Lessen the likelihood of burnout and/or return to active drug use by outreach specialists by instituting a quarterly weekend re-training and retreat program for staff members involved in street outreach. This would provide the opportunity to present updates on HIV disease, coping, and intervention skills. Various health professionals would be asked to conduct sessions.

7. Establish an advisory committee to serve as a program review panel and to review and assess the effectiveness of bleach distribution and other educational efforts. Encourage quarterly meetings and written evaluation of the program. Hire an outside contractor to evaluate the effectiveness of the bleach distribution program.

Cultural Appropriateness

Outreach had an established method of delivering culturally-appropriate services to the community (in the form of pamphlets, information, outreach specialists who were formerly addicted and/or HIV positive, etc.). The project employed, at various levels of time commitment, the principal investigator, an administrative assistant, two outreach specialists, and paid consultants to provide training and evaluation. Although all staff were African American, it was recognized that staff needed to be sensitive to the needs and experiences of recovering and HIV positive people of all racial/ethnic groups. Staff were also usually people in recovery and/or HIV positive.

III. PROJECT IMPLEMENTATION

The philosophy of Outreach centers around the idea that if a program is created and successfully tested, funding will follow. When Outreach applied for the OMH grant, it had already started performing street outreach and educational efforts, and it was certain of the need for its services in the community.

When OMH funding began, consultants provided teams of outreach specialists, called "Street Teams" with an initial intensive four-week training program that included program review, site visits to targeted areas, staff responsibilities, and current AIDS information. Primary intervention took place on the street, at or around housing projects, or other areas considered to be "hard core" drug areas. The project identified "satellite locations" that were visited weekly, and where materials were distributed. One-on-one interventions were also part of Outreach's approach, made with groups such as adult basketball teams, pool hall players, and homeless shelter residents. Outreach's Street Team made twice-weekly visits to identified high drug-use areas in the city to distribute condoms, information, and bleach. The distribution of bleach was the first to commence in Atlanta, and remains the only program in Atlanta to do so. Outreach designed a label for bleach bottles that it distributed. It developed a guide on "How To Clean Your Works," and developed and distributed a packet containing bleach instructions, brochures, and condoms. Outreach used a mixture of self-made and existing culturally-appropriate flyers and information materials to distribute during the street outreach, and to display at locations across the city.

Based on staff, volunteer, and client feedback, strategies were changed and modified as needed throughout the project period. For example, the project sought to establish weekly Alcoholics Anonymous, Narcotics Anonymous, and Cocaine Anonymous

groups during the project period. After having done so, they changed the times of the meetings from afternoon to evening, based on feedback. As a result, more people attended at the new time. Flexibility was further displayed by Outreach management's attention to the needs of staff. Twice during the project period, Outreach management and consultants provided weekend retreats for outreach staff to re-train, during which time individuals received burnout prevention, individual counselling, and group assessments of current outreach activities. Staff retreats are now held when monies are available.

An advisory committee to Outreach was formed in 1988-1989. It meets quarterly to review educational materials, data collection instruments, and outreach strategies. Outreach also has a Board of Directors made up of prominent and active community members. Both the Board of Directors and the advisory committee, composed mostly of original members, lend visibility to Outreach and keep the organization connected to prominent businesses and government in the city of Atlanta.

OMH funding made it possible for Outreach to use four outreach specialists during the project period. An increased number of outreach specialists made it possible for Outreach's Street Team to target 13 additional areas. After year one, the project found that once people had absorbed AIDS information, the priority became obtaining bleach. So packets initially designed to contain bleach, condoms, and information were broken down and the project began distributing materials separately. Because of feedback from outreach workers and other staff, the program shifted the strategy to include outreach to the streets surrounding targeted public housing sites as well as high drug areas. A range of culturally-appropriate and client-identified services were implemented at Outreach on an on-going basis. For example, during the third year, the outreach team began distributing cotton balls and alcohol sanitizing wipes with the bleach to help people clean their "works" better. The flyer "How to Clean Your Works" was revised to include how to use the cotton balls and sanitizing wipes, as well as a list of treatment facilities and HIV testing sites available in the Atlanta Metropolitan area. Outreach also established points of contact within health care facilities throughout the city in order to service indigent and drug-addicted clients.

The project first planned to ask the Fulton County Health Department to establish a mechanism for reviewing bleach distribution. After the first ten months, it was felt that the Health Department was not the appropriate agency. Outreach then hired a team of evaluators to conduct periodic reviews of the project, and to lend technical assistance to the project. The evaluation consultants provided information on the numbers of individuals reached through Outreach's program, and analyzed survey data.

IV. PROJECT OUTCOMES

Achievement of Project Objectives

In the years since the start of the HIV support group, attendance has grown from three persons to a current average of 30-40 people at each meeting. Clients articulate their feelings about Outreach, stating, "Outreach accepts people from all walks of life," "Outreach means what it says," and "Outreach is a caring place." There is little staff turnover at Outreach, but if individuals move on, they have been able to find other positions that use the expertise they gained at Outreach.

Since Outreach started its free and anonymous HIV testing program, there has been a significant 60-80 percent average return rate for post-test counseling. Although it was the first free and anonymous testing for the African American community in Atlanta, people from all ethnic backgrounds and economic means use Outreach's testing services.

As Outreach has grown, collaboration and connections with other community-based organizations and with state and federal agencies and institutions have helped foster strong ties needed to deliver services to the community. A common phrase used by other service providers when they need help with a client is, "Call Outreach."

Based on the goals and objectives stated in Outreach's application to OMH, the project achieved and surpassed its objectives. However, the nature of the organization makes it hard to distinguish where the impact of the OMH grant, specifically, can be shown. With the exception of bleach distribution, Outreach was performing, albeit on a smaller scale, all the activities of the OMH grant before OMH funding. The OMH project helped Outreach to solidify its community presence, create credibility for its organization and activities, and become more structured. It is not due to one grant, however, that Outreach achieved success or access to its community; rather, it is the spirit of the organization to first be of service to their community, and that the funding will follow. It is this intangible element involving commitment, caring, and mutual "family" support that sustains the essential activities, and helps make the program successful by and for the community it serves.

Outreach did achieve tangible outcomes. For example:

- . At the start of the OMH project, 10 high drug user areas were identified by the project. By the end of the contract period, outreach specialists were making visits to 13 additional areas. Outreach specialists distributed a total of 6,241 packets (+ 3 gallons) of bleach, 229,499 brochures, 497,111 condoms, and made 27,474 contacts on the street. At the end of the project period, Outreach had literature displayed at 30 locations, with 12 additional retail locations to be added.

- Local in-patient drug treatment facilities accepted referrals from Outreach by the end of the project period. Relationships were established with the Fulton County Alcohol and Drug Treatment Facility (outreach specialists provide a bi-monthly AIDS education and awareness session to inpatients and returning outpatients.) Outreach also established relationships with other community health and social services providers.
- The OMH grant allowed Outreach to begin distributing bleach. Since then, it has been the only organization in the city to dispense bleach as an AIDS prevention activity.
- Other outcomes that measured the success of the project included: (1) a high response rate to using bleach as a cleaning agent for drug "works," (2) increased awareness that AIDS was spreading in the Black community, (3) an increase in individuals seeking or thinking about testing and seeking drug treatment at available facilities, and (4) an increase in the number of males stating they use condoms.

Influence on Providers/System

Outreach established relationships with a number of service providers, community agencies, and local businesses from the beginning. One of the goals of the OMH project was to develop a list of local retail businesses and establishments who would display AIDS-related literature. By the end of the project period, the materials were displayed at over 40 retail and business locations throughout the area. Outreach Specialists developed relationships with health care and treatment facilities, among them the Fulton County Health Department, the city's Infectious Disease clinic, the city's only public hospital, and other private and public health facilities. They now serve as consultants providing pre- and post-test counseling, conducting bi-monthly, AIDS education lectures for inpatients, and assisting clients in accessing treatment through the health care system. By doing so, Outreach increased the provision of essential primary care and treatment services to addicted and/or indigent individuals. For example, a relationship with a local hospital's OB/GYN Clinic help start an outreach intervention effort aimed at minority pregnant and/or addicted female patients and their partners.

The Outreach office established the only weekly support groups for HIV seropositives in Atlanta during the project period, as well as Alcoholics Anonymous, Narcotics Anonymous, and Cocaine Anonymous groups. The Outreach Street Team, though varying in size over the six years of its existence, has never missed delivering outreach services twice weekly to neighborhoods around the city. This consistency has solidified Outreach's reputation and given it credibility in the community. The program also started an AIDS 1-800 telephone information line, to make it easy for clients to get in contact with Outreach. The number is listed on informational pamphlets that are made and distributed by Outreach. Calls have been received from people as far away as Arizona.

Project Continuation

Today, Outreach is a multi-faceted, comprehensive health facility, still providing essential services to individuals who are HIV positive and/or addicted. Free services to the community include: free and anonymous HIV antibody testing; individual and group counseling; medical transportation; referrals; home visits for PWAs; outreach street teams to specific areas; family support groups; women's support groups; self-help groups for addiction; a 1-800 number for people to call; and a mother-to-mother program for HIV positive mothers and their children. Outreach also provides workshops and seminars on HIV/AIDS and on addiction and recovery, and provides technical assistance to community-based organizations. Outreach is also involved in HIV/AIDS advocacy across the nation.

Unanticipated outcomes

- Outreach has attracted a cadre of professional volunteers.
- Outreach now sponsors hospital-based peer counselors, and people who provide services to people with HIV/AIDS who are in the hospital.
- The Latex Lovers Street Team was formed, which reaches out to a gay and bisexual clientele in clubs, around cruising areas, and at house parties.
- Outreach's relationship with the hospital OB/GYN Clinic led to successful intervention with minority females who were pregnant and had a history of substance abuse, as well as the development of a joint funding proposal between these two agencies.
- Outreach convened a coalition of five agencies concerned about AIDS in the Black community and received \$32,000 from the United Way of Metropolitan Atlanta to provide support for an interagency AIDS event and a series of follow-up training sessions. This link led to the formation of an interagency support group (Street Team Outreach Workers Coalition) for outreach workers and their supervisors.
- In 1990, the President and Founder of Outreach was elected Chairperson of the National Minority AIDS Council for the year; received the Atlanta City Council's President's Award for Distinguished Public Service; and was profiled in *The Wall Street Journal*, along with an outreach team member for an article about self-help groups in the Black community.
- The services provided by Outreach has helped forge career paths for staff and volunteers. Recovering and/or HIV positive individuals have been placed at local health departments, clinics, hospitals, and the court system.

- Outreach's staff has received invitations to share experiences and methods at national and international forums. During the project period, Outreach staff provided technical assistance, training, and educational sessions for various government, state, and community-based organizations.
- New programs that expand services to the community include:
 - . The MOMS (Mothers Offering Mothers Support) program, a program that connects retired women to younger HIV positive women with children. Started in 1991, the MOMS program recruits older women from Senior organizations and churches to volunteer. MOMS participants receive training and education at Outreach and then start their work conducting home visits and assisting peer counselors with caseloads. To date, 11 MOMS have been trained.
 - . The victim witness assistance program places an Outreach representative in the court system to counsel and recommend offenders for treatment.
 - . The homebound support program, where Outreach representatives provide services (e.g., go shopping, bring medication) for HIV positive people who cannot leave the house.
 - . A support network for infected and affected children, those who are children of HIV positive parents, and/or who have the virus themselves.
 - . Outreach conducts AIDS education community workshops for a variety of audiences throughout the metropolitan Atlanta community and the southeastern United States. Locations include church and civic groups, schools, treatment facilities, and job training programs.

V. LESSONS LEARNED AND SUGGESTIONS

Lessons Learned

- The positive impact of this project was due to Outreach's understanding of the social and cultural environment concerning addiction within minority communities.
- A community-oriented approach to outreach made it possible for the project to reach the "hard to reach" target population. Outreach Inc. accessed minority recovering substance abusers and persons with AIDS to provide outreach services, and lead support groups, among other things. They prove that a peer-focused approach works in providing HIV/AIDS educational and/or recovery services.

- Project staff and volunteers identified lessons learned based on their experience working with Outreach. Most said they had received an education while at Outreach, both mentally and spiritually. Keys to being effective in this work, and being part of a team include: listening, being non-judgmental, and being flexible and open-minded to other people. Staff members stated that this kind of work is not done for a paycheck.

Suggestions for OMH

Outreach staff and clients identified areas where they believe local, state, and Federal agencies could best direct their support and resources.

- There is need for additional funds, staff, and other resources to duplicate or increase Outreach's services, and the need for a satellite office in another part of the inner-city.
- OMH should allow past funded programs that have demonstrated success in their respective communities to either obtain more funding or to provide technical assistance to other community-based organizations that OMH is funding.
- Outreach to youth is greatly needed for both affected and infected survivors.
- Clients would like to see a skills training component as part of any program helping people with AIDS who are in recovery.
- Monies are needed for: transitional periods (i.e., the time between diagnosis with the virus, and the start of benefits or coverage); housing for PWAs; legal fees that may be incurred if a person loses his or her job; food; transportation; case management and staff to handle case management; and burial expenses.
- The nature of AIDS public service announcements needs to depart from the "doom and gloom" perspective and concentrate on the fact that people are living with AIDS, not just existing with AIDS. Positive communication could be achieved in the form of a newsletter directed to staff and clients of community-based organizations.
- More appropriate and affordable health care and social services, especially treatment centers, and female-focused interventions are needed for indigent populations.
- Advocacy is needed for patient rights concerning health issues.

PROJECTCASESTUDY

AIDS Workshops for Minority Service Providers in Hawaii Honolulu HI

In 1988, OMH made a three-year HIV/AIDS Education/Prevention Grant to the Kalihi-Palama Immigrant Service Center (KPISC, now the Immigrant Center) in Honolulu, Hawaii, to develop AIDS education manpower and culturally-sensitive materials to facilitate the acquisition of AIDS information for providers rendering services in Asian and Pacific Islander immigrant and refugee communities on four islands of Hawaii.

I. THE CONTEXT

The Setting

Between the enactment of the Immigration Act of 1965 and 1988, Hawaii received more immigrants and refugees proportional to the population than any other state in the Union and over four times the national average. According to the Hawaii State Department of Health (HDOH), there was a dramatic rise of immigrant arrivals in the U.S. in general, and in Hawaii in particular, between 1967 and 1987. Most arrivals came from the Philippines, South Korea, China, and India. Following the withdrawal of U.S. troops from Vietnam in 1975, refugees from Vietnam, Laos, and Cambodia further expanded the Asian immigrant population of Hawaii. According to the 1980 census, 14.2 percent of Hawaii's population was foreign-born. Of the foreign-born, 81.7 percent was Asian and Pacific Islander. At the same time, the proportion of Asians in the U.S. as a whole was only 1.5 percent.

The majority of Hawaii's immigrants and refugees live on the island of Oahu. Over 80 percent of them reside in the Honolulu area, where employment opportunities are greater and public transportation is available. Yet language barriers and culture shock deter immigrants and refugees from seeking assistance and gaining knowledge about available services.

Health Status

According to 1988 reports from the Centers for Disease Control and Prevention (CDC) and HDOH, Hawaii has a much higher proportion of AIDS cases whose ethnicity is "Other/Unknown" than is the average for the U.S. On the national level, one percent of AIDS cases are of "Other Unknown" ethnicity. In Hawaii, 17 percent fall into that category. Among the 40 cases in Hawaii in 1988, 34 (85 percent) were found on Oahu, the highly-populated capitol island where Asian and Pacific Island immigrants and refugees are highly concentrated.

According to studies and the experience of KPISC, there are a number of factors that influence the lack of knowledge of AIDS information among immigrants and refugees in Hawaii. They include: (a) a low awareness of susceptibility; (b) lack of knowledge of the risks of prevalent male-male sexual behavior that in some cultural contexts is considered neither unusual nor necessarily associated with homosexual orientation; (c) discomfort in discussing AIDS issues with family members, peers, and members of social networks; (d) health workers and service providers who very often do not know where to begin AIDS education efforts; (e) language and cultural barriers that prevent immigrants and refugees from seeking help regarding AIDS information; and (f) scarce accessibility of culturally- appropriate AIDS information and consultation.

According to the Hawaii Office of Community Services (HOCS) and HDOH, there are over 200 agencies providing health, social, education, and recreation services to immigrants and refugees on Oahu. Twenty-one of these agencies received contracts from OCS during the project period. Case referrals and joint programs have become common. Through these cooperative efforts, agencies have strengthened their ability to serve and reduce overlapping services. An inter-agency committee facilitates interaction among these service agencies, and directors of agencies meet monthly to solve current problems in delivering services to their clients and to plan for the future.

II. PROJECT INITIATION

Antecedents

KPISC did not provide HIV/AIDS education/prevention services before the OMH grant.

Organization

KPISC is a private, non-profit organization and a subsidiary corporation of the Episcopal Church in Hawaii. It was founded in 1973 in response to the dramatic increase in Asian and Pacific immigration in Hawaii. It is funded in part by the Aloha United Way, and also receives Federal, state, and local monies in addition to private and individual donations.

KPISC is the only private, non-profit human **service** agency in Hawaii whose sole purpose is to assist immigrants and refugees in resettlement and readjustment. A Board of Directors consisting of church-related people and community leaders governs the center. In 1985, the center served 11,955 families and more than 19,000 individuals. Over half of the new incoming immigrants and refugees live in the Kalihi-Palama area in Honolulu.

The main function of KPISC is to facilitate the adjustment to American society and culture of Honolulu's Asian and Pacific newcomers (especially Chinese, Korean,

Laotian, Filipino, Samoan, and Vietnamese) so that they can become socioculturally and economically self-reliant in the U.S.

Project Goals and Objectives

The project's goal was to prevent a long-term increase in the number of AIDS cases among refugee and immigrant populations. The three objectives were to:

1. Develop and implement training workshops for service providers.
2. Develop a culturally-sensitive HIV/AIDS education handbook for service providers to refugees and immigrants and for other concerned individuals.
3. Conduct outreach to immigrants and refugees in the local community.

The project's target population was composed of service providers in immigrant and refugee communities in Hawaii. By the end of the second year, there were three major sources of target population: private, non-profit agencies contracted with HOCS; agencies in the HDOH; and agencies on three islands in addition to Oahu — Hawaii, Maui, and Kauai.

Design

The major components of the project were:

Formation of Advisory Committee: An advisory committee was formed at the beginning of the project. The members consisted of the project director, an HDOH consultant; members of other service agencies, and professionals from the Bilingual Access Line, a non-profit telephone information line set up by the state. The major function of the advisory committee was to **provide consultation** on program planning, implementation, and evaluation. Monthly meetings were held.

Training Workshops: According to the grant application, the health educator in consultation with the HDOH was to conduct a total of six training workshops, with three sessions each. Sessions one and two were to be conducted over two consecutive days, and session three would follow two months later.

Educational Outreach: These activities included displays at cultural and health fairs, production and distribution of condom novelty items, distribution of brochures in target languages, and integration of HIV/AIDS education into other educational programs offered by the participating agencies.

HIV/AIDS Training Handbook: An HIV/AIDS training handbook containing information on approaches to HIV/AIDS education was developed by the end of year three for service providers to refugee and immigrant communities in Hawaii. Material in the handbook was based on experience acquired and feedback received over the previous two years from educational outreach activities and the training workshops.

Initially, the project staff consisted of only a program director at 30 percent time. A health educator (100 percent) and an administrative assistant (50 percent) were then added. The director's responsibilities included the initiation and maintenance of positive relations with involved persons and agencies, coordination of program activities, production of annual reports, and the identification of future funding sources. The health educator was responsible for developing training workshop and teaching materials, conducting and monitoring program implementation, and developing the AIDS education handbook. The administrative assistant did the bookkeeping and data management. The project had two directors during the grant period — one male and one female. Both the health educator and the administrative assistant were female.

The Minority AIDS Education Coordinator for the HDOH was the program consultant. Her primary responsibilities were to train the project's health educator and to provide technical assistance throughout the implementation phase of the project.

The health educator communicated with the trainees in multiple languages, and group discussion was a common feature of all training sessions. Group discussion facilitators from the same ethnic group(s) as the trainees were pre-trained to maximize communication of key issues. Cultural barriers to HIV/AIDS education were identified and strategies to overcome them were discussed during training workshops. HIV/AIDS information brochures were translated into several different languages, and the project used ethnic-specific posters.

Evaluation Plan

Process evaluation was carried out through questionnaires given to participants at the end of each workshop to assess their views of workshop content and presentation styles. Regular staff meetings and quarterly reports were additional measures used for process evaluation. A pre/post-test developed by project staff was used at workshops to measure the change in HIV/AIDS knowledge and attitudes of participants. The pre/post-test results, verbal feedback from workshop participants, and regular project staff meetings were essential sources of information for the design and refinement of the HIV/AIDS handbook.

III. PROJECT IMPLEMENTATION

At the start of the project, it became clear that the project title — AIDS Workshop for Minority Service Providers — was inappropriate because Whites are the minority in

Hawaii, and the primary recipients of the training were bilingual service providers. Thus the project was renamed the HIV Education Workshops for Immigrant and Refugee Service Providers.

The needs assessment gave service providers the opportunity to contribute to the workshop content and structure. Accordingly, changes were made in both as the project staff gained experience and receive feedback. Interviews and meetings with people from within refugee and immigrant communities played a major part in developing the handbook. As drafts of each relevant chapter were completed, they were given to several people from each community for their comments and suggested changes.

Training Workshops

Originally, the project proposed a total of six training workshops, with each workshop consisting of three sessions. Sessions one and two were to be conducted over two consecutive days, and the third session was to be conducted two months later. Two problems were encountered. First, service providers were reluctant to devote such a large amount of staff time to workshops. Most of the agencies were understaffed, given their caseloads, and sending staff to three one-day sessions would have reduced their capability to serve their clients. Second, staff turnover was quite high in some agencies. This lowered the likelihood of continuity among workshop participants. Consequently, the workshops were tailored to fit the availability of agency staff. Workshops were scheduled to run from one and one-half to four hours, with follow-up sessions held when feasible. With most agencies, the total number of hours of training was close to that in the original proposal.

Workshop content was developed based on the needs assessment of twenty agencies conducted early in the project. The health educator developed two survey instruments for service providers to determine educational needs. By the end of the first year, 12 of 22 service providers contacted had completed the needs assessments survey with service recipients. The workshops were structured to be as effective as possible, given the constraints mentioned above. The training modules included basic information on HIV/AIDS, identification and overcoming of cultural barriers, the psychological and social impact of HIV infection, counseling and testing, substance abuse and HIV, **STDs**, TB, Hepatitis B and AIDS, and illness and death.

The project adopted a team approach to organizing and conducting the workshops. Two staff members from **KPISC** — the health educator and the administrative assistant — did the pre-workshop preparation and also participated in the workshop sessions. Consultants and resource persons were brought in as needed, including several people with AIDS, HDOH staff, educators from non-profit organizations (including the Life Foundation, Wai'anae Coast Comprehensive Health Center, and Kokua Kalihi Valley Health Center), and educators from the University of Hawaii.

Because of the fear and stigma associated with HIV/AIDS, individuals with HIV or AIDS from the immigrant and refugee populations were reluctant to speak at the workshops. The project had to rely on gay white males as speakers, thus reinforcing the misconception that AIDS is disease that afflicts only white, male homosexuals.

At the end of year two, the project staff concluded that educating service providers and outreach workers about HIV/AIDS issues was insufficient for actually getting the information out into the community. Most workers admitted that they lacked the ability to discuss their newfound knowledge with their clients because of shame, embarrassment, or lack of culturally-appropriate ways in which to disseminate this type of information. A generic strategy to overcome this problem was the development of "Welcome Packets" for new immigrants/refugees and first-time clients. The packets included pertinent financial, social service and health information (including HIV/AIDS) in the language of the client.

The workshop curriculum was modified to train participants to provide clients with a brief summary of the information contained in each packet, including basic information on HIV/AIDS and the ramifications of this disease to the individual client and his/her family. Trainees were also instructed to encourage clients to discuss any questions they might have about any of the materials contained in the packet with KPISC staff.

Educational Outreach

HIV/AIDS educational sessions were conducted in churches, social clubs ethnic bars, and other locations where the target populations naturally gathered. These activities included participation in various cultural fairs and exhibits, production and distribution of condom novelty items (condom leis, earrings and flowers), distribution of brochures in different languages, integration of HIV/AIDS into other programs offered by the agencies concerned, and involvement in planning two Pacific Region HIV/AIDS prevention conferences.

The condom novelty items proved very popular and provided a stimulus for discussions about AIDS prevention, as well as for breaking down people's reluctance to talk about condoms. As a result of the popularity of these items, project staff were often invited to demonstrate how to make condom novelty items in workshops and seminars organized by other groups in the community.

HIV/AIDS Training Handbook

The HIV/AIDS training handbook was developed by the project for AIDS educators from immigrant and refugee communities. The methodology used to develop the handbook was to use a range of sources. These sources included the service providers' workshops, other published materials, interviews, meetings with individuals and groups from refugee and immigrant communities, and experiences of project staff

in a variety of educational outreach activities.

Since English is not the first language of more than half of the workshop participants, it was anticipated that sections of the handbook would have to be translated into Lao, Vietnamese, Cantonese, Korean, Ilocano, and Tagalog. To date, KPISC has not found monies to do so.

Monetary/In-kind Donations

Many agencies provided resource materials, workshop supplies, and various kinds of information to augment the projects resources. These agencies include HDOH, the Waikiki Health Center, the Gay Asian Pacific Alliance, Asian Health Services, and the Association of Asian/Pacific Community Health Organizations.

Staff Changes/Modifications

The project had two project directors over the three-year funding period, but no other staff changes. However, frequent personnel turnover in participating agencies was very common, and presented a number of challenges to the project.

IV. PROJECT OUTCOMES

Achievement of Project Objectives

Evaluation data in the project's final report indicate that there was an increase in knowledge and a change in beliefs among participants as a result of the workshops. HIV/AIDS education has been integrated into other educational programs, as well as incorporated into staff in-service training at KPISC.

There has been only a slight increase in reported AIDS cases among Asian and Pacific Islanders since the project's inception (from 17 percent of all reported cases in Hawaii in 1988 to 20 percent in 1992). The project final report acknowledges that:

"... while it could be argued that this relatively slow rate of increase could be attributed at least in part to increased educational efforts, the main impact of this project and others which have targeted Asian and Pacific Island communities will probably not be seen for two or three more years, given the extended period of time between infection and the development of AIDS related symptoms" (page 6).

Project Objectives Outcomes

1. About 500 service providers working with refugee and immigrant communities participated in the workshops during the project period. Between 63 and 44

percent of workshop participants completed both the pre and post-test. Out of a perfect score of 25, the average was 20.56 pre-test and 22.64 post-test.

Several problems were experienced in attempting to have participants complete both pre and post-test. For example, some participants came late and missed the pre-test, others failed to complete the post-test. Different levels of participants' ability to read and write English was also a problem. Due to the small numbers of the latter it was decided that it would not be feasible or cost-effective to translate the questionnaires. Consideration was given to eliminating the test for some individuals. Despite these problems, the project continued to administer the tests at most of the workshops, and the results show an increase in knowledge and a change in attitudes for those who completed both tests.

2. Project staff sponsored or participated in a number of outreach activities, including cultural and health fairs, distribution of brochures, and integration of HIV/AIDS education into other programs offered by the Center. They also played a key role in planning a Pacific Region HIV/AIDS prevention conference.
3. The HIV/AIDS Training Handbook was produced for service providers. In addition to basic information about HIV/AIDS, the handbook contains culture-specific information relevant to Hawaii's refugee and immigrant communities. The handbook clearly fills a gap in existing HIV/AIDS educational materials for refugees and immigrants. However, dissemination to service providers has been delayed pending funding to cover printing and distribution costs. None of the service providers interviewed during the site visit had copies of the handbook. Funds to translate the handbook into major refugee and immigrant languages are still being sought.

The HIV/AIDS workshops with service providers were a valuable source of information, particularly in identifying culture-specific barriers that might hinder AIDS education efforts, and in providing strategies to overcome these barriers. All of this information is reflected in the HIV/AIDS Handbook.

Condom novelty items (condom leis, earrings, flowers, and pins) were also produced. These proved to be popular and effective as "conversation pieces" to stimulate discussion on AIDS prevention.

Influence on Providers/System

The cooperative working relationship between service providers continues and appears to have been strengthened. The main focus of the project continues to be primarily educational. Currently, KPISC does not receive funding from the HDOH. However, HDOH does share other HIV/AIDS resources, such as resource personnel, for HIV/AIDS workshops and educational materials. The Center is recognized by some

government agencies as the lead agency for mobilizing refugee and immigration social service agencies. For example, the manager of a public housing project near the Center's office recently contracted the Center to organize an on-site health fair for residents who are predominantly immigrants and refugees. This demonstrates the cooperation shared among service organizations in the community. In the future, the housing project manager plans to expand this service to other housing projects in the area.

Project Continuation

Resources to continue the original project have been secured after a hiatus of several months. There appears to be a strong commitment to HIV/AIDS education/prevention among the KPISC Board of Directors, even though there has been a complete change of personnel at both levels. The KPISC HIV/AIDS program now focuses on youth: six peer educators from six major immigrant communities in Hawaii (Chinese, Vietnamese, Filipino, Korean, Samoan, and Laotian) have been trained and are now supported in their efforts through a CDC grant.

A full-time HIV/AIDS coordinator is on staff to plan and direct KPISC HIV/AIDS programs and to coordinate activities with other CBOs and providers. HIV/AIDS education has been integrated into non-health related programs at the Center. For example, a two-hour HIV/AIDS component has been included in the Immigrant Job Readiness Program, which is a ten-week occupational skills and pre-employment training program for adult refugee and immigrant clients. The system of distributing HIV/AIDS materials in the respective languages of the Center's refugee and immigrant clients has been maintained.

Unanticipated Outcomes

- The project has provided an opportunity for participating agencies and individuals to initiate open discussion and take action on a wide range of women's issues.
- HIV/AIDS education has been integrated into most of KPISC programs and services.
- A Core Cultural Competency Group, consisting of representatives from participating and collaborating agencies, has been formed to focus attention on this issue.
- A KPISC staff member who assisted the HIV/AIDS Project Director is now the HIV/AIDS Education Coordinator at the Kokua Kalihi Valley Health Center. She has added an HIV/AIDS TV program to an on-going, call-in radio program she produces for the Samoan community. The radio program was initiated

during the OMH project period. Her primary target group has changed from adults to teens.

- Another trainee from the Wai'anae Coast Comprehensive Health Center has been promoted from HIV/AIDS education coordinator to assistant administrator of the health center. She has initiated the integration of HIV/AIDS education into the health center's substance abuse prevention program.
- The project frequently receives requests for condom novelty items and educational materials from agencies and individuals from other states.

V. LESSONS LEARNED AND SUGGESTIONS

Lessons Learned

- Training service providers with HIV/AIDS information alone is not enough. Skills and confidence to communicate the information to their clients using culturally- sensitive methods are essential.
- Administering pre- and post-tests at workshops has its disadvantages that may make this approach to evaluation counterproductive. Pre/post-tests, for various logistical, cultural, and practical reasons, were not always administered.
- It is necessary to tailor workshops to fit the working circumstances of individual agencies (e.g. caseload, staffing levels), and availability of agency staff.
- Frequent staff turnover and competing internal agency priorities present severe challenges to training activities.
- A project of this nature has to depend upon people from the target community to educate others. Close attention must be given to their motivation, confidence, and training to serve in this capacity.
- Those trained service providers who followed through used a variety of their personal networks (e.g., cooking and sewing classes, church groups) as well as job related channels, to pass on HIV/AIDS educational information.
- Too much attention to issues of sensitivity and culturally-correct language during training can lead to less time in conveying factual information about HIV/AIDS and prevention.
- Humor is a viable culturally-congruent vehicle for HIV/AIDS education — and other health-related education — in some immigrant and refugee communities.

- It is very difficult to sustain contact with and provide support for service providers who are trained and serving on outer Hawaiian islands.

Suggestions for Project Improvement

- Targeting a broader range of service providers (e.g., community group leaders, teachers) for HIV/AIDS education training is an outreach strategy that should be considered.
- More hands-on activities should be integrated into the workshop training methods to make them more practical. For example, include skill-based training on methods to pass on information and knowledge to clients of service providers.
- Hold HIV/AIDS update workshops periodically for service providers who have participated in the project. The strategy to channel HIV/AIDS education through workers at immigrant centers should be continued because there is a high level of trust between workers and clients.
- The Workshop curriculum should include strategies for handling in-house bureaucracy and how to administer and process **pre/post-tests**.
- Use condom novelty items to attract and involve teens and peer educators.

Suggestions for OMH

- Organize grantee meetings more often than once a year. They are good for sharing ideas and networking.
- Pacific Islanders are underrepresented in the decision-making process locally and nationally. OMH should ensure that this group is represented where needs of minorities are addressed.
- Projects need more technical support during the early stages of design. Where feasible, steps should be taken to identify and use local experts who can assist projects.
- Instruct the OMH Resource Center to reproduce and make the handbook produced by projects available to interested individuals and agencies.

PROJECT CASE STUDY

Education for Black HIV Positives in Metro-Detroit Detroit MI

In 1988, OMH made a three-year HIV/AIDS Education/Prevention grant award to the Community Health Awareness Group (C-HAG) in Metro Detroit, Michigan, to provide HIV positive African American individuals and their families/significant others with post-diagnostic skill-building education and health awareness information, and to provide support groups and networks.

I. THE CONTEXT

The Setting

When C-HAG started in 1985, there were no services in Detroit that addressed or met the needs of HIV seropositive African American individuals. C-HAG is a community-based organization staffed by Black men and women from within the target community. It began by providing members of the Black community with AIDS education, anonymous HIV counseling and testing, and critical intervention and support group services. C-HAG's idea for the OMH grant was to provide post-diagnostic skills-building education that emphasized health maintenance, stress reduction, and communication skills for HIV seropositive individuals and their family members or significant others.

Health Status

The HIV virus hit the urban Black community in Detroit with a disproportionate impact. In 1988 it was estimated that approximately 45 percent of Michigan's population diagnosed with AIDS were Black, and about 45 percent of that population resided in the metropolitan Detroit area. Three hundred and ten Blacks in Michigan had been diagnosed with AIDS. Detroit ranked second in the United States, next to New York City, in the number per capita of IDUs. The level of knowledge in the population about the virus was estimated to be limited. This may have been due in part to the fact that there were very few services available to the Black community at the time of this grant. C-HAG was the only CBO serving the needs of seropositive African Americans in Metro Detroit that provided AIDS risk-reduction education, counseling and testing, crisis intervention, and psycho-social support services. It was perceived that these services were necessary but fell short of meeting all the needs of Black persons who were HIV seropositive in managing their own health.

II. PROJECT INITIATION

Antecedents

The project sought to address the issue of HIV seropositivity and AIDS risk behaviors among African American men and women and their partners and/or families. Many clients at C-HAG were substance abusers and/or homosexual. Most clients of C-HAG had little access to medical care, transportation, appropriate housing, and social support. A baseline study was conducted before C-HAG wrote the grant proposal for OMH monies. Experiences of clients in C-HAG's support group indicated the need for skills development in implementing risk reduction for seropositive individuals and their sex partners beyond that provided through risk-reduction education. It was also observed through experience that family members sometimes play a pivotal role in influencing behavior. Education of family members, including risk management and care of seropositive individuals, was pursued in order to help break down the barriers of fear and denial associated with HIV.

C-HAG remains the only community-based organization in Detroit that serves the African American community. C-HAG's mission is organized to address current health issues and concerns of the Black community and to develop effective ways of promoting and implementing positive health strategies to influence the overall quality of life of Black citizens of Detroit. C-HAG's staff members are from backgrounds similar to those of the target clientele.

C-HAG has consistently collaborated with the Detroit Department of Health in developing AIDS-related education materials and risk reduction services. Starting in 1985, C-HAG has, with the support of the health department, provided street outreach, outreach at substance abuse centers, outreach to community groups, HIV antibody testing and counseling, crisis intervention, and referral services to the Black community in Detroit.

Project Goals and Objectives

The project goal was to enable clients to manage their health and to change their HIV-related risk behavior so that the spread of HIV within the metro Detroit African American community could be reduced. Specific objectives were:

1. To develop a network for referrals, provide a post-diagnostic education program to 100 seropositive persons and 200 family members, and establish a Family Advocacy Group.
2. To design a lecture curriculum for HIV seropositive persons and their family members and establish a 60 percent client completion rate of lecture series.

3. To develop home-based learning activities for HIV seropositive persons and their family members.
4. To develop a risk profile of African American seropositive persons in metro-Detroit.
5. To develop a marketable post-diagnostic learning module, and to market to 40 local health care centers.

Design

Based on its experience in providing AIDS outreach, counseling, and testing, C-HAG saw that HIV positive clients needed services and skills aimed at coping with (living with) HIV infection and needed expanded services, including post-diagnostic education and counseling in the form of health-related awareness and skills-building.

Program components included the following:

- Skills-building education provided through a 12-part lecture series delivered twice-weekly by guest speakers to C-HAG clientele. The focus was on caring for seropositive family members or self, and managing risk behavior and health. Confidential counseling and HIV antibody testing were offered. Topical areas in the lecture series included risk management and health management.
- Home-based education, which sought to develop health management skills in an individual home setting. Education consisted of nutritional counseling, social service counseling, community resource referrals, and general home care information.
- A Family Advocacy Group, which was planned to operate independently of C-HAG. The Group trained family members of seropositive persons to provide peer services in AIDS education, grief counseling, mutual emotional support, and community advocacy.
- A referral program by other city AIDS providers, which was ongoing throughout the project period. C-HAG received referrals from local hospitals and health care services, and used these ties to recruit individuals for the intervention program.
- Cooperation with the Detroit Department of Health, which assisted in the development of all educational materials and in training local health care providers. It also served as a resource of guest lecturers for the skills-building sessions.

Cultural Appropriateness

The goal of C-HAG was — and is — to effectively address the health care needs of Detroit's HIV seropositive and at-risk Black population, and, by extension, that of Detroit's Black community in general. The C-HAG staff demographically reflected the target population of the project, used appropriate language in addressing their clients, and provided ongoing suggestions that helped shape appropriate program activities and services. The C-HAG staff designed the program to respond to the needs of the clients (e.g., providing transportation or taking information to them, following a flexible format in lecture presentations, being responsive to the requests of the clients).

III. PROJECT IMPLEMENTATION

During the first months of the project, educational materials used for the lecture series were developed. These materials were designed with the target population in mind. They were designed for a sixth grade reading level (easy to comprehend) and contained colloquialisms and standard terminology to enhance comprehension. Skills-building lectures were begun in early 1989 and continued in a six-week format for the remainder of the grant period. The lecture series consisted of twice-weekly, two-hour lectures followed by a discussion period. Once a week, there was a support group with a one-hour lecture, followed by discussion. The program specifically addressed stress management, communication skills, and mental attitudes of seropositive individuals.

Intervention sites used by C-HAG included local churches, clinics, and other public facilities where they could reach African Americans. These facilities were used to conduct skills-building education during the day as well as for the once-a-week night lecture. Average attendance numbered 55-60 people per week, the majority of whom were seropositive gay African American males. Each lecture was followed by a set of related activities including role plays, values clarification exercises, and small group discussion. C-HAG also disseminated bleach, condoms, and printed materials at each session. A clinic education component was added during the first year, and was carried out at Wayne State University's University Health Center three times per week. The University Health Center was providing the bulk of care for indigent HIV seropositive individuals in the Detroit area at the time. Additionally, C-HAG implemented an education program that featured "house parties" hosted by community members. This was funded by the United States Conference of Mayors in the first year of the OMH grant. C-HAG conducted further home-based education or home visits which addressed living situations of clients and families, and provided one-on-one counseling.

C-HAG was closely involved with the Detroit Department of Health and other local and state AIDS and health-related task forces. In addition to the program coordinator and outreach worker at C-HAG, professional staff from the Detroit Department of Health

provided technical assistance to the project and gave presentations to project clients. They usually received an honorarium from C-HAG. Participants who completed the family skills-building program lecture series and were certified by C-HAG were asked to provide volunteer educational services through other C-HAG program components,

Clients were recruited to the C-HAG skills-building through pre-existing ties to community (including counseling or substance abuse referrals, other support groups, and local health or service agencies.) Clients in turn were asked to recruit their families to participate in the skills-building education. Skill-building education and health education for seropositive persons emphasized constructive ways of living with HIV — a much-needed service for those diagnosed seropositive. For people like substance abusers or sex workers, who are often disenfranchised in the health arena, this education assisted them in AIDS risk reduction and in overcoming the barrier of fear.

Group activities (e.g., dinners, movie nights, cultural events around the city) provided social support opportunities for people who were often marginalized because of their sexual orientation, who had substance abuse problems, or who had seropositive status. The project invited feedback from clients and colleagues, and consequently changed the program accordingly to meet the client and target population's needs.

The group became the focal point of intervention, and an essential mechanism in dealing with HIV for all people C-HAG served. The group welcomed both infected and affected individuals to discuss relevant issues, and participants expressed their loyalty to the group in terms of it being a "family" for them.

Modifications

The first program director resigned in August 1990 (a year and a half into the project); the program coordinator then moved up into this position, and the outreach worker became the program coordinator. The outreach worker role was initially intended for two part-time workers. However, during the first year, the role was consolidated into one full-time position. Despite the staff turnover, the project goals and objectives were achieved.

During the project period, C-HAG staff realized that African American heterosexual seropositive women were hard to reach. The program coordinator initiated a women's support group to be held in the evenings once a week. The forming of the **women-only** weekly support group fulfilled a need for individuals who were hard to reach and retain in risk reduction education. However, C-HAG identified the need of more support for women, especially heterosexual women without children.

The Family Advocacy Group was formed in response to the need for seropositive clients to have family support without having family members, necessarily, in their HIV support group sessions. Persons affected by the virus were welcome to attend the

HIV support group for infected individuals, but it was clear that they needed their own vehicle to deal with their specific issues. This Group did not meet initial expectation.

In planning the project, C-HAG hoped to be able to market its series of skills-building education lecture curricula to other CBOs in and around Detroit. However, the C-HAG staff realized that this idea was impractical due to the competitive nature of AIDS programs in the area. It was found that other organizations would replicate their methods and apply for the same funding, rather than purchasing the component from C-HAG. Consequently, C-HAG did not find the opportunity to market the training module.

Evaluation

A Knowledge, Attitude, Behaviors (KAB) study was completed during the project period. It provided a rough demographic breakdown of client characteristics and provided program feedback from clients and colleagues. Additionally, C-HAG administered behavioral assessment surveys to compare to baseline data. Condom and bleach distribution were monitored and cross-checked with client reported use, and data were collected monthly from presentations and home visits. A post-test comprehension quiz and an evaluation form were designed to measure participants' response to the lecture and allowed for client feedback. Lecture and workbook materials and participation were periodically reviewed and updated to reflect the needs identified in the evaluation process.

V. PROJECT OUTCOMES

Achievement of Project Objectives

Project reports indicate a 60 percent client completion rate for lecture series, a 50 percent increase in condom use, and a 60 percent increase in bleach use by injection drug users. Client participation in skills-building education and use of other services of C-HAG continued after the lecture series (i.e., grant period) ended. Clients gave themselves the name of "The Family," which expressed their pride in their participation with the skills-building program. Today, C-HAG operates with a larger client base and offers increased services to address the complex needs of its target population, including those of housing, childcare, foster care, counseling, medical services, and transportation.

Impact on Providers/System

C-HAG has been and remains an important link between mainstream health service organizations and the underserved Black community. Despite the fact that local politics determine the allocation of resources away from minority service organizations,

C-HAG continues to provide case management and support services to the target population beyond that of larger service agencies.

Because of the reputation for delivering needed services that the project gained during the grant period, C-HAG has received increasing numbers of referrals from city-wide agencies. C-HAG continues to deliver effective services for HIV seropositive individuals, and is now working with the Michigan Department of Social Services to bring the Family Advocacy Group together.

The project was perceived by C-HAG staff to be replicable in other settings across the country because it addressed the many social and cultural issues associated with the disease.

Project Continuation

C-HAG still exists with state and Federal funding for certain programs and components. Client retention in the program was considered highly successful, and experienced continued growth and participation throughout the OMH funding period. However, there were not as many family members of clients educated in the skills-building program as anticipated, and C-HAG was unable to obtain funding for the skills-building program due to state budget cuts. C-HAG funding has also been hampered by politics at the local and state level, in part due to increased competition in the city of Detroit for funds among organizations that claim to serve the needs of clients with the HIV virus. C-HAG was and remains instrumental in providing services to communities of color in the city of Detroit. Yet, this organization fears it is being left behind despite its attempts to obtain monies.

C-HAG's short-term goal is to make the skills-building part of the women's support group, and to continue other activities until funding is attained. The long-term goal is to seek other resources, and to continue and replicate services. Reference materials developed by C-HAG have been disseminated at local state and national seminars, conferences, and workshops.

Today, C-HAG continues to provide comprehensive services to its community, including: case management, food and housing, medical referrals, testing and counseling, family support, outreach, home and hospital visits, and group social activities. C-HAG staff have consistently devoted extra time to carrying out all activities and services C-HAG offers. In the words of one staff person: "We accept people from all walks of life — people here are like a family; and (we) have respect for one another's jobs."

Unanticipated Outcomes

- The Men of Color Motivational Group was started out of the offices of C-HAG by Black gay men involved in support groups at C-HAG. This group was formed to address the issues of Black gay men. Specifically, its goal was to educate, empower, and motivate men of color to achieve their potential in a positive environment. Since its inception, Men of Color has operated on the efforts of its volunteer membership, which supports events, educational materials, and weekly meetings for Men of Color in Detroit. Recently, Men of Color won its first grant to help its' members continue the supportive forum it provides. Men of Color's weekly meetings have an attendance of 20 to 150 individuals.
- New Generations Youth Support Group, formed out of Men of Color, addresses the issues of gay youth. Both groups have weekly and monthly newsletters, which are professionally and voluntarily written, produced, and published by group members.
- C-HAG was able to secure a grant to buy a van for the organization to help transport people to weekly group meetings and other group activities. Although the van is helpful, C-HAG still needs to borrow vans from the Department of Health to accommodate the number of people attending the support group meetings.
- C-HAG now performs an "AIDS 101" lecture at the Wayne County courthouse for people who are to be released from court for misdemeanors. C-HAG is the only other organization, besides the Department of Health, that provides this service.
- The women's group for HIV seropositive women started during the project period, and it has become a successful and integral part of C-HAG's services.
- C-HAG is looking to establish a satellite office at a local housing project. Its staff hopes to be able to educate young people about drugs and AIDS awareness, do testing and counseling, and form adolescent and adult support groups.

V. LESSONS LEARNED AND SUGGESTIONS

Lessons Learned

- It is necessary to meet people where they are, and to answer their immediate needs. Organizations should remember that education is not the most

important thing when there are other immediate needs that clients require (food, clothing, shelter, health services). Education is only part of the process.

- It is perceived that the way to get resources and services in the city of Detroit is based on who knows who, and not who needs what. C-HAG continues to lobby the city and the state government to obtain funding.
- The state AIDS service providers need to be monitored or examined in order to ensure that employment (hiring), representation, and distribution of resources fairly serves all communities in metropolitan areas.
- The trend in funding favors large AIDS agencies, which often do not provide the range of services for people infected and affected by HIV that are provided by CBOs.

Suggestions for Project Improvement

- Funds should be provided in the following areas for programs addressing HIV/AIDS issues:
 - support and relief for families caring for infected individuals
 - foster care and support groups for children whose parent(s) is(are) HIV positive
 - support groups in general for people infected and affected
 - budgets for food service and transportation for clients of CBOs
 - health care coverage for employees at CBOs
 - capacity-building monies for CBOs
- Since a Board is an important mechanism in the growth and visibility of an organization, the emphasis in Board selection criteria should stress individuals' activity and advocacy rather than academic credentials.
- To avoid complications in allotment of funds and/or revocation of grant monies, state and Federal agencies should establish rules and regulations regarding grievance procedures for grantees.
- Better benefits packages (salaries, health care) should be provided for staff of CBOs to attract and retain their services.

Suggestions for OMH

- It is necessary that OMH remain in existence and be willing to invest more time and resources in minority, CBOs. Now that OMH has brought people “to the table,” it is important to sustain their involvement and/or offer continuing support and advocacy for those projects that it has helped along. Both sides will benefit from an on-going exchange, regardless of whether OMH is providing funding or not.
- Funding for CBOs should by-pass state and/or county health departments to help avoid tying up money and/or organizational politics.
- Technical assistance is needed to help CBOs work successfully with their Boards, especially in the areas of understanding budget priorities; understanding project functions; and how best to use their Board members.
- Technical assistance is also needed in the areas of grant writing, evaluation, information systems management, and how to obtain computers and other hardware needed for expansion of organizational capacity.

PROJECT CASE STUDY

Minneapolis Indian AIDS Prevention Risk Reduction Project Minneapolis MN

In 1988, the Office of Minority Health awarded a three-year grant to the Indian Health Board of Minneapolis, Minnesota (IHB) to reduce the transmission of AIDS in the Minneapolis Indian community through collaborative community-based education and prevention strategies.

I. THE CONTEXT

The Setting

The Indian Health Board is a community health center whose service area is defined by the user population, the majority of whom are Indians who are concentrated in neighboring census tract areas. These areas represent similar populations and economic patterns.

According to available census figures (1980), American Indians have the largest number of families living below the poverty level and the highest percentage of persons living below the poverty level. Both American Indian males and females have the lowest representation in the work force, and the American Indian has the lowest median income of all racial groups.

Traditional beliefs in Indian communities are very important in addressing issues that affect Indian groups and in helping Indian people accept and/or change behaviors. Indian culture — encompassing the body, mind, spirit, and feelings — has proven to be an essential tool in HIV/AIDS education/prevention activities among the Minnesota Indians. There are a total of 63 Indian tribes in Minnesota.

The initial target community was the Indian youth of Minneapolis and the Indian Health Board clients. Indian youth were involved through the school system, alternative Indian educational institutions, and other community agencies. Indian reservations and penal institutions were targeted as requests were received for HIV/AIDS information and as the popularity of the project increased.

Health Status

Although Indian people comprise less than one percent of Minnesota's population, ten percent of all admissions to the State Regional Treatment facilities are Indian, 22 percent of all admissions to the Hennepin County Methadone Maintenance clinic are Indian, Indians comprise eight percent of the state's prison population, and 12 percent of the juvenile corrections facilities population. These characteristics are said to

increase the risk of HIV infection. The population targeted was also perceived to be at high risk for HIV because of such other factors as their high rates of sexually-transmitted diseases. Factors that influence or are associated with the high incidence of STD's include substance use and abuse, multiple sexual partners, pre-adolescent sexual experience, and gay and bisexual behaviors or lifestyles.

Up to 1987, the reported number of cases of HIV/AIDS in the state for the Indian population were not available, as the category of "other," meant to include anyone that was not Black, White, or Hispanic, was not broken down by the CDC or the Minneapolis Health Department. In late 1987, the Minnesota Department of Health identified the "other" race category as Asian/Pacific Islanders and American Indian/Alaskan Native. In May 1988, the American Indian Health Care Association reported that the majority of AIDS cases were reported in urban areas, and that over half of the Indians in the U.S. resided in urban areas. Of the number of Indians with HIV, the average age was 32. Eighty percent were male, 56 percent were identified as homosexual or bisexual, 14 percent were injection drug users only. Four percent of HIV infections were attributed to blood transfusions or hemophilia, and seven percent occurred in children and/or adolescents. Of nine individuals who tested positive at the Indian Health Board of Minneapolis, five were Indian.

II. PROJECT INITIATION

Antecedents

The IHB of Minneapolis was the first urban Indian health program in the United States to be funded through a direct line appropriation from Congress in 1972. IHB is set up as a community clinic providing medical, dental, and mental health services to a primarily Native American population. Its mission is to serve as a contractor for Federal and other existing funding sources in administering a comprehensive health program to meet the needs of Indians living in urban communities. It is overseen by a Board of Directors representing both users and areas of professional expertise. In 1986, The Indian Health Board was the first urban Indian health program to receive accreditation from the Joint Commission on Accreditation of Hospital and Ambulatory Care Facilities. The Indian Health Board has also achieved many national "firsts" in program services for urban Indians.

In 1976, IHB submitted documentation to Congress as to the needs for urban Indian health care programs to direct health care services in a culturally-sensitive, community-based setting. As a result of this documentation, the government has sponsored over 30 urban Indian health programs throughout the country.

In 1987, the IHB and a number of other state and local community organizations interested in addressing the issue of AIDS participated in a Minneapolis forum to

develop AIDS awareness and educational activities. As a result of this forum, entitled "AIDS and the American Indian Community," the Minnesota AIDS Project (MAP) formed the Minnesota American Indian AIDS Task Force, a network of concerned individuals that was charged with developing a statewide plan on AIDS **for the Indian** community. The Task Force incorporated in 1989. Other than this assistance from the Minnesota AIDS Project and some assistance for seminars and workshops, there was no formalized HIV/AIDS education/prevention effort in the Indian community at the time of the grant, although there was cooperation between Indian health organizations and the state.

Design

Because no other agency had initiated HIV/AIDS educational programs for Native Americans, the OMH grant was the first organized attempt to establish and operationalize such a program at a facility serving mostly Indians. It was designed to establish AIDS education and prevention at the IHB, and to continue beyond the grant period. The program was intended to focus initially on IHB clients (approximately 6,000 in 1988). IHB staff were trained to provide risk-reduction educational material for clients, primarily youth, who were chemically dependent, persons in treatment, persons requesting family planning information, persons requesting pregnancy testing, those testing positive for sexually transmitted diseases, and those who had multiple sexual partners.

IHB staff also provided education to other existing organizations and facilities through response to direct requests and the sponsorship of statewide and local workshops on AIDS.

An all-Indian project staff consisted of the project director (10 percent time), AIDS educator/coordinator (100 percent time), and a case manager (hired in 1991 at 100 percent time). As the project staff gained experience, the methodology used to educate youth was refined through participant feedback at the end of each session. Periodic IHB staff review meetings were also held. Feedback from teachers and counselors from participating schools was encouraged.

Project Goals and Objectives

The project's goal was to reduce the transmission of AIDS in the Minneapolis American Indian community through collaborative community-based education and prevention strategies. Approximately 600-700 individuals, primarily youth, in the Indian community were to receive education on prevention of HIV.

The project's objectives included the following:

1. Identify AIDS-related activities as they pertain to the **IHB's** organizational

structure. Develop a curriculum for IHB staff addressing HIV and AIDS prevention and advocacy issues. Develop a procedural manual to incorporate into the IHB Principles of Practice and Policy Manual.

2. Develop in-service training and education for all IHB staff and providers (approximately 65 people). Provide four hours of AIDS education to 80 percent of the IHB staff.
3. Identify or develop AIDS education materials specific to the Indian population. Identify and develop population-specific educational materials, posters, and brochures for the Indian population.
4. To promote and participate in joint efforts to prevent the transmission of AIDS in the Indian community. Coordinate with the Minnesota American Indian AIDS Task Force to develop community education strategies. Sponsor conference and/or community training forums on HIV/AIDS. Provide AIDS in-service training to at least five Indian organizations and their staffs. Develop a brochure for the distribution of the video of Carol LaFavor, A Spiritual Journey with AIDS. "Her Give Away."
5. To promote safe sex practices among the IHB's sexually active pre-adolescent, adolescent, and adult clients. Provide 80 percent of IHB family planning patients with AIDS risk reduction counseling. Perform follow-up visits with 80 percent of those who received counseling.

Cultural Appropriateness

Strategies employed by the AIDS educator embraced the Minnesota Indian culture and were designed to appeal to the age group and maturity of the audience, e.g., educator sitting in a circle and at the same level as much younger children, the use of humor, healing ceremonies, and social events such as Pow Wows. It should be noted that a peer education strategy was not used by this project. Peer educators are successful when three things are available: community support; money, staff time and resources; and proper and comprehensive training for staff and peer educators. In the opinion of the project coordinator, the most one can hope for as a result of peer education is an open door to the issue (and there is a need to be careful the door is not slammed shut as a result of inappropriate material for the audience), and that the peer educators will be role models of the desired behavior. At the time of the OMH grant, it was determined that it was more appropriate to focus instead on working with the larger community for an extended time (2-6 weeks) to create a "community of acceptance" and to work on decision-making and skill development.

Educational sessions were conducted where the target population naturally gathered, e.g. schools, reservations, health centers, community centers, and churches.

Typically, the project director was invited by an institution or a community leader to speak to a defined audience. Usually, a series of sessions were held with each audience. They were described as “spiritually”-based and holistic in approach, covering a wide range of biological, social, cultural and emotional **issues, not just** “basic” HIV/AIDS information.

III. PROJECT IMPLEMENTATION

Most of the HIV/AIDS educational materials used by the project were developed by Native American projects outside the state. However, the project produced some brochures that were considered to be very effective by the project target population. Materials such as posters and brochures used Indian symbols and an appropriate level of English for the intended audience. A very popular feature of the project was the design and production of novelty items made from condoms, e.g., single stem multicolored flowers. The project director would occasionally dress as a “condom clown” to emphasize the importance of prevention.

The Minnesota Indian AIDS Task Force produced a video called “Her Give Away” about an Indian woman’s life journey with AIDS. This proved to be a very effective tool in AIDS prevention education among Indians. The Task Force also produced a play that addresses HIV/AIDS issues among youth.

Additionally, the project developed:

- An AIDS Prevention Planning Guide, a Community Overview inventory form, and a questionnaire designed to elicit a participant’s knowledge of AIDS before and immediately after education and technical assistance workshops.
- Policy and Procedures Protocols for HIV/AIDS-related issues: Statement on Confidentiality, Employee Rights, Equal Access to Service, and Unfair Procedures in Treatment or Testing.
- Curricula for presentations to first, second, third, and fourth graders, a general AIDS presentation outline, and a conference/training evaluation form.
- Video order forms (“Her Give Away” and “David’s Song: American Indian Teens and AIDS”), educational material price list and order form, and the National Native American AIDS Prevention Center Resource List.

The project began with IHB staff. The project coordinator trained them in basic **information about** HIV/AIDS and invited one or two to accompany her during

educational sessions to co-present and/or answer questions related to their fields of expertise. This partnership within the agency strengthened the project and contributed to its effectiveness and longevity. The project coordinator has responded to requests from Indian institutions and agencies both within and outside the state to train staff members to conduct HIV/AIDS educational programs.

The primary intervention sites were selected public and alternative Indian primary, middle, and high schools. Periodically, sessions were held at women's shelters as well as at adult and juvenile correctional institutions. A series of presentations were made at all twelve reservations in the state over the course of the project. This involved travelling long distances and necessitated the project director being away from home for extended periods of time. HIV/AIDS educational programs were also held at health department clinics, health fairs, an Indian summer school, community-based organizations, in-state and out-of-state conferences, workshops, support group meetings, youth leadership retreats, and youth centers.

During the project period, a Women's Sexuality Group was started to help women talk about sexuality and issues surrounding sexuality, such as love, relationships, abortions, and rape. Impetus for the creation of this group came from outreach workers who were finding that their pre-natal clients had little understanding of their bodies and reproductive functions and/or prevention of pregnancy. Transportation for meetings was made available to anyone interested in attending.

The HIV/AIDS services available at IHB were: individual risk assessments for HIV infection; pre- and post-HIV antibody counseling and testing; case management for HIV positive individuals and their families; individual and community education about HIV and risk reduction; support services for HIV-positive individuals and their families; and comprehensive primary medical care for HIV-positive individuals.

The project was originally designed for youth, but responded to requests from all age groups. The project director's knowledge and ability to address a number of related topics (e.g. human sexuality; human anatomy; physical, social, and emotional changes of adolescents; dating and boy-girl relationships; and culture) were often mentioned. These sensitive topics were honestly and openly discussed at a level appropriate for each audience.

An important value to Indian people is the use of humor, usually in the form of "the trickster," a traditional character who uses humor to educate or teach. During the project period, the IHB AIDS coordinator dressed up as a condom clown while passing out condoms and talking about AIDS. She first performed at an educational community fair sponsored by IHB, and it was successful enough to be replicated at other HIV/AIDS events and appropriate educational sessions. The HIV/AIDS project also sponsored the visit of a Chippewa medicine man for three days. He provided communal healing, blessings, and individual healing during his stay. Additionally, a

"naming feast" and "Give A Ways" were held for individuals. Although his coming was advertised only by word-of-mouth, there was an excellent turnout for all three days. Some project modifications had to be made during the project period. For example, the Women's Sexuality Group had to be restructured because it was felt that there was no incentive to bring the women in to talk. A case manager was given time on the project in January 1991 to provide case management services to HIV/AIDS clients and their families. Health educators and support group facilitators also provided support group services to HIV/AIDS clients, yet none of these services were part of the original project proposal. They evolved as needs were identified.

Project personnel noted that the evaluation component of this project was the most difficult aspect based on the fact that it is difficult to monitor actual long-term behavior change in a three-year period of time, particularly with the pre- and post-tests, which were not always appropriate to use. It was reported, though, that the use of incentives for the post-test in the form of small gifts significantly increased the completion rate. Most people preferred anonymous HIV/AIDS testing, and therefore it was not possible to track follow-up action and outcomes of those persons who attended the project's educational programs.

Qualitative evaluation measures included peer review of presentations and information, and subjective assessments of the trust gained from the community and general acceptance of the methods used to present AIDS information.

IV. PROJECT OUTCOMES

Achievement of Project Objectives

- In retrospect, the project staff feels that the project goals and objectives were realistic and that their achievements have exceeded targets and expectations. The AIDS coordinator stated that it took her two years to gain the trust of the IHB staff, community, teachers, and students. Project staff reported a significant increase in community participation in IHB-sponsored events throughout the project period. People also showed their interest and attention by often visiting the IHB after a community education session was given to ask questions and obtain follow-up information.
- Collaboration and cooperation were key issues for the IHB. Project activities constantly sought collaboration with local, state, and Federal agencies that address Indian issues and AIDS. Their hard work on this goal has led to the formation of the Minnesota HIV/AIDS Consortium, which involves state, county, city, and local agencies. Its goal is to strengthen the communication of organizations providing HIV/AIDS services. The project AIDS coordinator is also a member of the recently formed Community Planning Group mandated by CDC to identify HIV/AIDS related needs and draw up plans for meeting them.

Impact on Providers/System

- The AIDS coordinator has personally accomplished many things during the project period and beyond. She was selected and certified by the National Institute for Drug Abuse (NIDA) for training in substance abuse and AIDS; she has been invited to sit on state subcommittees for adolescent health and AIDS; she is involved in national planning committees for addressing AIDS services; and she serves on many minority advisory committees and educational review committees.
- IHB produced two articles for the National American Indian Media Consortium, which were printed in various papers across the country.
- The OMH grant assisted in IHB establishing HIV/AIDS-related services.
- IHB is working with national Indian health organizations to build a national coalition for Indians around HIV/AIDS-related issues. IHB has co-sponsored Indian health care conferences that emphasize a holistic approach to reducing the risk of HIV/AIDS, including Indian spirituality.
- IHB provided technical assistance to several local reservations, as well as to other in-state and out-of-state organizations, on developing a community plan of action for AIDS services and caring for HIV/AIDS clients and their families.
- In January 1991, the IHB used state funds to hire a case manager who began to help the project coordinator with AIDS-related educational and training tasks. The case management program is a collaborative agreement with the county medical center and Metropolitan Hospital to determine gaps in service. Unfortunately, the state health department withdrew funding for IHB case management for the 1994 fiscal year. This is a disturbing development, since it is unlikely that other agencies are capable of providing case management services in the same culturally-sensitive manner as the IHB staff.
- One of the major accomplishments of the program was the integration of HIV/AIDS into all clinic services. A distinguishing feature of a series of "AIDS 101" educational sessions was the inclusion of related topics, such as anatomy, sexuality, self esteem, communication and relationship skills, **sexually-transmitted diseases**, and family planning.
- IHB also was and still is a key provider of technical assistance in policy development on HIV issues and lends technical assistance on long-range planning activities to a number of Federal and state funding agencies

Project Continuation

A smaller budget for outreach has resulted in a reduction in the number of educational sessions in any given quarter. The same high level of personal commitment and sacrifice that characterized the staff during the OMH grant period are still evident. The commitment of IHB to HIV/AIDS issues has remained, even though the funding has not. Currently, there are three full-time positions: AIDS project coordinator, case manager, and a health educator/LPN.

The Minnesota Indian community continues to be receptive to the projects HIV/AIDS educational efforts. Some target population agencies would like to have HIV/AIDS educational activities more frequently, but budget constraints do not permit the coordinator to provide them. Support from parents and elders is strong. The project was couched in traditional cultural values at the beginning, which may explain this unusual phenomenon.

The AIDS coordinator's full time position is now supported by the IHB's unrestricted funds and the state health department. IHB health center staff continue to participate in outreach educational activities on an as-needed basis. Close collaboration with the city health department and the Minnesota AIDS Task Force continues. In general, networking and collaboration between the project and city, state, and federal agencies involved in HIV/AIDS and Minnesota Indian reservations remain strong.

Unanticipated Outcomes

- The Women's Sexuality Group was organized to address a need identified during the OMH funding period.
- The AIDS coordinator serves on several state, regional and Federal boards that focus on HIV/AIDS among minority populations. She is frequently invited to train HIV/AIDS service providers in educational outreach.
- The AIDS coordinator was given an award by the County of Hennepin in June 1994 as a positive community role model because of her work with the project.

V. LESSONS LEARNED AND RECOMMENDATIONS

Lessons Learned

- Be honest and respectful with the people with whom you want to work. Tell them exactly what you are willing to do, can do, and cannot do. It is important to meet with school teachers and parents to orient them and develop strategies before making presentations to students.

- Prevention must include skill-building and support to help youth make good decisions. Generally, Indian youth know the basic facts about AIDS. They need skills and practice in making good decisions.
- Statistics and other facts about illness, dying, and death have very different meanings in different cultures. It is important to recognize the different cultural understandings on these issues. Whenever possible, a member of the target population should present the information.
- Active racism still prevails in the government decision-making process. Participation in decisions that affect Indian lives — including money-related decisions — should be stressed.

Mobilization around HIV/AIDS issues needs to be positive, not negative and angry.

- Youth should be actively involved in HIV/AIDS education in order to create positive and widespread change in the community.

In order to bring about change, there needs to be a strong network of committed people who feel similarly about the issues.

Suggestions for Project Improvement

- Integrate HIV education and direct services into community health care settings, especially in rural settings and in racial/ethnic minority communities.
- Establish a fund to plan fun activities for youth that will promote trust between the project staff and the youth.
- Train a critical mass of youth as peer educators for HIV/AIDS outreach.
- Enlist the help of graduate students to document program processes and refine project documents.

Suggestions for OMH

- Find out if the applying Indian agency is qualified to receive a grant before awarding it.
- Provide technical support at critical stages of grant application, implementation, and evaluation.
- Provide feedback on periodic project reports.

- The need for community-based research information is vital to understanding the health needs of the minority community. Often, state, university, or Federal researchers do not accurately assess or understand the situation of specific communities.

PROJECT CASE STUDY

The AIDS/HIV Education and Deterrence Program (AHEAD) Helena MT

In 1989, OMH made a three-year HIV/AIDS Education/Prevention grant award to the Montana United Indian Association (MUJA), a statewide association of seven Indian alliances based in Helena, Montana to assist Native Americans living in urban communities throughout Montana to develop their own community-based and culturally-appropriate AIDS/HIV education/prevention programs and AIDS training manual. After training, a community-based approach was used by alliance representatives who planned and carried out their own HIV/AIDS education and prevention programs, with MUJA technical and financial assistance.

I. THE CONTEXT

The Setting

The project's target population was non-reservation urban Montana Indians between the ages of 13 and 65. Emphasis was placed on reaching young adults, youth, and their parents. Elders were also considered important because their advice carries great weight in the Indian community, and a special effort was also made to include tribal leaders and medicine men.

Seven urban Indian alliances were targeted by this project: Anaconda, Billings, North American, Native American Center, Helena, Indian Educational Development Alliance, and the Native American Service Agency. The major tribal groups served by the project were: Flathead Reservation, Crow, North Cheyenne, Assiniboine, Fort Peck Sioux, Gros Ventre, Chippewa, Chippewa/Cree, Blackfeet, Salish-Kootenai, and Big Sky.

Health Status

The major health problems among urban Indians in Montana were reported to be: (1) alcohol and drugs; (2) tuberculosis (3) diabetes; (4) heart disease; (5) suicide; and (6) HIV/AIDS. The 1991 Montana Department of Health and Environmental Services Surveillance Report listed seven cases of AIDS among resident Native Americans. The estimated number of HIV/AIDS case among Native Americans in Montana is estimated to be over 210 in 1994. Native Americans make up six percent of the population in Montana. Despite the fact that Montana has the fourth lowest rate of HIV/AIDS among Native Americans in the U.S., seven percent of reported HIV/AIDS cases in Montana are Native Americans. This figure may not take into account the fact that Native Americans are often classified under other racial/ethnic groups, thus reflecting a lower rate of infection under the Native American category.

The state runs ten HIV/AIDS testing centers that are supported with Federal funds. These testing centers offer a variety of other medical services and they are mainly staffed with non-Indians, which may inhibit use by Native American people. At least two health centers run by Indian alliances provide testing and counselling for its clients.

There appeared to be a high level of HIV/AIDS awareness among the trainees who participated in the three cluster HIV/AIDS workshops where there was an average pre-test score of 83 percent. A systematic measurement of the level of HIV/AIDS awareness among the general Native American population was not carried out before project implementation. The assumption was made that knowledge about HIV/AIDS was extremely low in this population because before this effort, Montana's urban Native Americans had not been targeted for HIV/AIDS awareness or educational programs.

II. PROJECT INITIATION

Antecedents

This project is a follow-up to **MUIA's** AIDS/Sexually Transmitted Diseases (STD) Grant from the Montana Health Services Division, under which **MUIA** developed appropriate AIDS/HIV training materials for urban Indians. Production of the materials was to be completed in October 1989 and this project was proposed to start November 1, 1989.

The Montana United Indian Association (**MUIA**) was incorporated in 1971 as a statewide non-profit consortium dedicated to the improvement of the social and economic welfare of the off-reservation Indian people of Montana. The consortium provides services through a network of local service centers in seven service areas located in Anaconda, Billings, Butte, Helena, Great Falls, Miles City, and Missoula. The central office of the Association is located in Helena and is responsible for the administration of all statewide programs while providing technical assistance to the local service centers. The **MUIA** Board of Directors is made up of one representative from each of the seven areas and one each from associated Indian organizations. All representatives are elected at open annual elections.

Montana is the third largest in size of the lower forty-eight states and has seven Indian reservations. According to the 1980 Census, there were 37,000 Indians in the state. The Census also indicated that one out of every four Indians resided in an off-reservation location. **MUIA** estimates that there are 40,000 Indians in the state, with about half living off reservations.

Since incorporation, **MUIA** has successfully administered a variety of service programs that include family planning, employment and training, mental health, child abuse,

elderly programs, education, comprehensive health services, and a crisis intervention program. Now alliances apply to Federal and the state government for their own funds. For instance, Helena, Billings, and Great Falls have their own medical clinics funded by the Indian Health Service. All programs are primarily funded with Federal dollars. Presently, the Montana Department of Health and Environmental Services does not give **MUIA** or any Indian CBO funds for HIV/AIDS education either from state or other funds it controls.

Design

An HIV/AIDS needs assessment was not conducted by the project. Justification for the project was based on Centers for Disease Control and Prevention data and from Montana Health Department sources, which reported 86 cases of AIDS among Native Americans in 1988. **MUIA** believed that this amount was grossly underestimated and that the potential for AIDS to spread in the Indian community was high. This belief was based on STD rates, morbidity and mortality due to substance abuse, and limited access to health care among Native Americans in general.

Project Goals and Objectives

The project goals were to:

- Encourage behaviors that reduce the risk of acquiring or transmitting AIDS/HIV.
- Increase locally developed prevention strategies.

The project objectives were to:

- Train a total of 60 AHEAD scholarship recipients on AIDS prevention.
- Provide informational “booster sessions” to energize participants and use focus group interviews to improve project results for the second and third year.
- Develop a Train the Trainer AIDS Manual: The Basics of AIDS tailored to urban Indians.
- Reach Indians through mass media, Pow Wows, workshops, schools, and special activities. Safe sex and the use of clean drug works were the behaviors promoted by the project.

The project involved three phases: planning, education, and preventive action:

Planning: MUJA worked through seven regional alliances to announce the AHEAD Program, and they jointly selected the local organizations and alternates that were given AHEAD awards. This phase consisted of two steps: (1) MUJA preparation of four sets of documents: a brochure, a leader packet, an AHEAD Packet, and a generic dialogue; and (2) dialogue with local leaders (youth groups, church groups, women's groups, and support groups).

Education: Sixty AHEAD participants were trained in three Regional Cluster Workshops conducted by MUJA. Two of the twenty participants from each cluster were designated as community educators who facilitated local workshops and trained 10 to 20 members of their community to become neighborhood counselors. The most successful AHEAD trainers were selected to facilitate similar workshops at state-wide annual Pow Wows in Montana.

Preventive Action: Trained local group members were expected to share their experience and knowledge during informational booster sessions and supportive networking developed by AHEAD participants. These sessions were conducted in years two and three of the project with groups that successfully completed their year one plans. They were designed to include updates on the latest research findings and information related to matters requested by the local groups. MUJA provided follow-up support, including training materials, a quarterly newsletter, and assistance in monitoring and evaluation. Monitoring and evaluation were continuous throughout the project.

Cultural Appropriateness

A variety of strategies were used to make educational sessions culturally appropriate, including setting up AIDS Tepees at Pow Wows; taking AIDS messages to Indians at their natural gathering sites (Indian Alliance Centers, gatherings at private homes, traditional feasts, bingo halls, youth camps, public schools and colleges, church gatherings, and hospitals); the use of incentives (T-shirts, stipends, and traditional foods/snacks); having an "Indian Feed" at participants' homes combined with an educational HIV/AIDS program; having a Native American with AIDS tell her story; mass media (radio and TV); and the use of culturally-sensitive pamphlets, posters, and brochures. Videotapes on AIDS produced by Native Americans ("Her Giveaway" and "AIDS: American Indians Dying Silently") and others from South Dakota and Alaska were used. It was considered extremely important for the educators to be accessible on a one-to-one basis after initial presentations to larger groups. The training manual that was developed by the project proved to be most useful and appreciated by Native Americans in and outside Montana. The "Wheel of Misfortune" — an educational tool developed by the Missoula Indian Center staff — was an innovation that also proved to be very popular during HIV/AIDS education sessions.

Evaluation Plan

Each workshop included a participant evaluation at the end. Periodic reports to OMH analyzed major conclusions and recommendations regarding AIDS education procedures and training materials that had proven effective in educating urban Indians in Montana.

Both monitoring and evaluation were integral components of workshops. A two part (pre-and post-test) evaluation was completed during each training workshop. Participants completed a questionnaire before the evaluation session, and participated in a discussion session that focused on how to improve the training. Most of the planned evaluation was formative rather than summative. After training, workshop participants submitted monthly reports to MUIA. This was the primary way of monitoring project activities at the community level. Semi-annual, quarterly, and financial reports were prepared and submitted to OMH.

III. PROJECT IMPLEMENTATION

The primary intervention components of MUIA's project included educational programs and outreach. All trainees were given the freedom to design their own educational programs to match the readiness of the target audience and choice of educational methods. The approaches used included: one-on-one counseling, mass media, tribal elders as peer educators, and traditional Pow Wows as educational opportunities. The predominant feeling among the health educators interviewed is that traditional attitudes and cultural barriers to openly discussing HIV/AIDS and related sexual issues have been extremely difficult to change and break through. In some cases, AIDS educators continued their educational programs at considerable emotional cost. Some were asked to leave tribal areas when elders on tribal councils became offended by the discussion of such topics. Two of the six health educators interviewed were ostracized by some of their own family members for continuing their HIV/AIDS educational activities over the objections of older relatives.

Culturally-sensitive brochures, pamphlets, posters, and radio and TV programs on HIV/AIDS were produced by the project. Each of seven tribal groups participating in the project selected representatives for the training of trainers workshops. Train the trainer workshops were conducted for youth and elders using a training manual, Train the Trainer Manual for American Indians: The Basics of AIDS developed by the projects. This is the project product of which all interviewees 'were most proud. All agreed that the manual needs updating, and specific suggestions are given in- Section V of this report.

Formative research allowed the participants to offer their input in the development of educational materials. Indian Youth Task Forces on HIV/AIDS have been established in Indian and public schools to provide opportunities for empowerment, program ownership, and the dissemination/use to a high-risk group through their own unique approaches and network system. The booster sessions for trainers were planned to update workshop participants on the latest HIV/AIDS information. In the experience of health educators interviewed, however, the booster sessions were primarily used to exchange information and experiences, and not necessarily to update their knowledge of current information on HIV/AIDS.

The major intervention sites where an educational HIV/AIDS program was given were the natural gathering places of Indians, e.g., Pow Wows, Indian Alliance Centers, private homes, bingo halls, youth camps, gay and straight bars, public schools and colleges, church gatherings, and Indian Feeds in homes or centers. The mass media (radio and TV) were used extensively in Billings and to a lesser degree in Missoula by the health educators trained by the project.

Outreach was mainly conducted by project staff health educators, including 22 youth and 43 adult peer educators. Through the collaboration with the Indian Health Services, Montana Office of Public Instruction, Indian Talent Search, and the Montana Department of Health and Environmental Services, the project was able to extend its outreach efforts.

IV. PROJECT OUTCOMES

Achievement of Project Objectives

The target to train 60 Indian youth and adult educators was exceeded by five. However, less than ten of those originally trained were known to be active in 1994. The pre-project estimated number of urban off-reservation Indians in Montana was 13,579. The estimated total number of project participants reached through the project was 14,582, including both on- and off- reservation Indian people. The anticipated number of tribal groups that were to be involved was exceeded by seven. **MUIA** exceeded all targets set at the beginning of the project.

Even though the project was designed by a non-Indian consultant from Washington, DC, the fact that all project staff, trainees, and volunteers were Montana Native Americans maximized the opportunity for the target communities to shape the project. Each served community selected representatives for training as health educators for the purpose of returning to their respective alliances to spearhead their own local HIV/AIDS education. Those trained had the freedom, and were encouraged, to design their educational programs to fit their audiences, and to use educational methods with which each felt most comfortable. There **was a concerted effort to appropriately blend**

HIV/AIDS educational messages with cultural institutions and symbols, e.g., setting up HIV/AIDS Tepees as informational centers during traditional Pow Wows.

Influence on Providers/System

HIV/AIDS testing was not available at most Indian alliance health centers, but staff referred those who were interested to existing health facilities during the project period. Now this service is offered at the three clinics run by Indian Alliances. More than 500 Indians are known to have received HIV screening as a result of this project. The project did not seek, nor was it given, follow-up information on referrals. Therefore, it is not known how many of the referred persons actually took the test or what were the results of the tests that were given. The latter was probably due to concerns about confidentiality. Follow-up procedures are still not in place at the three clinics run by their respective alliances. Those who wanted HIV/AIDS testing were initially referred to government health care facilities where educational sessions were held.

It is estimated that 5,500 condoms, 5,000 brochures and pamphlets, and 500 bleach bottles were distributed during the three-year project. Before this project, no other agency had targeted HIV/AIDS education to urban Indians in the state of Montana. Since OMH funding ended, **MUIA** has not been involved in HIV/AIDS education and preventive services. The state does not provide any funding to **MUIA** or to any racial/ethnic minority CBO for HIV/AIDS education. Nor is CDC funding to the state for HIV/AIDS education/prevention services channeled through racial/ethnic minority organizations in the state. Furthermore, no racial/ethnic minority citizen of Montana has ever been invited to speak at the annual state-sponsored HIV/AIDS conference since its inception in the early 1980s. These findings point to a lack of tangible state support for HIV/AIDS education among racial/ethnic minority populations. It should be noted that the state of Montana, under a CDC mandate, recently completed a study of its HIV/AIDS needs. When the results are published, a copy will be made available to the TI team.

The Department of Health and Environmental Services provided funds for **MUIA** to establish a statewide Minority Task Force on AIDS in year three of the project. However, members of the Task Force interviewed reported initial organizational problems e.g., meetings cancelled on short notice, and a lack of consensus on the purpose and direction of the organization. **MUIA** indicated that funding was insufficient for the Task Force to reach its potential during the project period. A few charter members of the Task Force meet occasionally to discuss issues related to HIV/AIDS education and prevention, but funding is still an acute problem. One representative expressed a desire for assistance from **MUIA** to obtain 501(C) 3 status, which would allow the Task Force to be independent and to qualify for direct funding. After this is accomplished, the Task Force's first task will be to revise the manual produced by the project.

Project Continuation

The **MUIA** continues to provide a variety of services to the Indian community. The executive director during the OMH project period has retired and a staff member who was with **MUIA** for a number of years and who is familiar with the project is now acting executive director. However, **MUIA** has not continued to provide HIV/AIDS education services to member alliances since the end of OMH funding.

The former **MUIA** executive director met with Montana Health and Environmental Services key staff to explore ways to continue collaborating to combat AIDS and to develop short and long range program strategies so that the positive outcomes generated by this project would not be lost. **MUIA** estimated that funding for two outreach coordinators plus **\$60,000** per year is required to support the training and booster sessions developed by this project. The Tribal Law Enforcement Agencies are prime resources for replication and they have indicated an interest in doing so. However, to date, none has done so.

MUIA obtained foundation funding to keep the HIV/AIDS project director on board to provide technical assistance and lend support to urban Indians HIV/AIDS programs for about two years after OMH funding ended. He left **MUIA** when funds ran out.

Unanticipated Outcomes

- The training manual has been requested by numerous tribes throughout the U.S. and Canada.
- A Blackfeet Indian law enforcement training officer has requested permission to use the **MUIA** Training Manual for the development of a training package for the Blackfeet police department.
- The Montana Minority AIDS Task Force was organized during the last year of the OMH project to coordinate statewide efforts to address the HIV/AIDS problem among all racial/ethnic minority groups.
- **MUIA's** final HIV/AIDS-related program activity at the end of OMH funding was to provide financial and manpower support to promoting HIV/AIDS educational programs for the Little Shell Indian tribe. These are landless Indians who are recognized by the state but not by the Federal government.

V. LESSONS LEARNED AND SUGGESTIONS

Lessons Learned

- There is a perception that the State treats Native American CBOs differently from White CBOs. Two respondents stated that a significant number of Montana Indians feel that the AIDS epidemic is an attempt by the majority population to commit genocide against Native Americans and other ethnic minority populations.
- This project began the effort to break through the prevailing denial that HIV/AIDS affects and should be a concern of Indians in Montana. Though attitudes have been difficult to change, the project has broken new ground in openly addressing the problem of HIV/AIDS among a significant portion of Montana's Native Americans.
- The frequency of travel from reservations to urban areas, and the mixture of people from various tribes out of state as well as on/off-reservations, necessitates the focus of AIDS education on the total community.
- AIDS messages should strive to combat the belief that AIDS is a disease that infects only the "gay" individual or the "drug user."
- The speaker on sexual matters must be mature and comfortable discussing issues related to sex, i.e., not discussing sex as being bad, but addressing the risk factors if one engages in risky behaviors, such as having sex without the use of condoms, and anal intercourse.
- There is a need to talk with tribal medicine men to seek their involvement in HIV/AIDS education and prevention programs.
- Several participants who were trained described personal benefits from the project on their participant evaluation forms. These benefits included feeling more self-confident and sensitive as an AIDS educator and counselor, and working with special targeted groups such as pre-release prisoners.

Suggestions for Project Improvement

- During training, more emphasis should be placed on topics of sexuality, self-esteem, shame, denial, substance abuse, mental health, and behavior.
- HIV/AIDS statistics should be made public on a regular basis throughout communities to make people realize that there is a serious problem and that

each individual must make changes within the community to remedy and slow down the infection rate.

- Add chapters to the training manual on: (1) a holistic approach to HIV/AIDS prevention, including spiritual aspects; (2) the psychosocial aspects of AIDS, including self-esteem, self worth, unresolved grief, and how these issues predispose one to risky behavior; and (3) approaches and educational materials for teens.
- The training manual should list support agencies that provide testing and counseling.
- All HIV/AIDS state and local training programs, seminars, etc., should include representatives of high-risk target groups.
- Information about alcohol/drug treatment programs should be stressed in all HIV/AIDS educational/prevention programs.
- Health facilities should devise a medical record system that guarantees confidentiality. This would greatly reduce the fear that many Native Americans have that someone other than themselves may find out about their test results.
- The Indian Health Service and the state should organize HIV/AIDS policy seminars for tribal leaders. Rather than concentrating on basic HIV/AIDS topics, the seminars should concentrate on the status of the epidemic among Montana Native Americans, socioeconomic implications, and the roles of tribal leaders in HIV/AIDS education and prevention programs.
- Establish an Indian Youth Task Force on HIV/AIDS in each of the tribal and urban high schools with a large number of Native American youth. There is a need to target AIDS messages to youth from broken families since they seem to be more involved with alcoholism and sexually transmitted diseases. Outreach workers are needed to go to Indian bars, prisons, vocational technical schools, etc., to do some down-to-earth HIV/AIDS education and develop intervention strategies. More attention to follow-up is needed to build on success with schools, health officials, tribal officers, and key workers.
- Continue to capitalize on the use of traditional Indian symbols that reflect Native American spiritual and cultural beliefs for HIV/AIDS education/prevention, e.g., by putting condoms in traditional medicine bags that are distributed at cultural events.

Suggestions for OMH

- Provide additional funds for the reproduction and distribution of costly educational and training materials, e.g., videotapes, training manuals/curricula.
- Increase grants to at least \$100,000 per year, and increase the grant period.
- Provide technical assistance at critical stages of project development and implementation.
- Continue to provide grants directly to CBOs.

Educational Materials Produced or Used by the Project

** Train the Trainer Manual for American Indians: Basic of AIDS, Montana United Indian Association, Helena, MT, 1989.

AIDS and other **STD's**: Indians at Risk (Brochure), Native Americans Service Agency, Indian Health Services, Seattle Indian Health Board, Seattle, WA.

HIV Antibody Test (Brochure), Department of Health and Educational Sciences, Helena, MT.

Montana Response to AIDS Hotline - 1-800-233-6668

Montana AIDS Cases Monthly Surveillance Reports

"A Health Crisis", A Special Report on Montana's Indians, School of Journalism, The University of Montana, (undated).

** Produced during OMH funding period.

PROJECT CASE STUDY

HIV Risk Reduction Among Atlantic County Black Youth Atlantic City NJ

Blacks Against AIDS (BAA), a minority community-based service organization, was founded in Atlantic City NJ in 1987 by a group of concerned Black and Hispanic health care workers, community leaders, and concerned citizens in response to the high prevalence of HIV/AIDS among minorities in New Jersey. The purpose of BAA is to promote the structural integrity of the minority community by providing minority-sensitive education, skilled support, and a comprehensive resource base to individuals, families, and communities in Atlantic County in an effort to combat the spread of AIDS.

I. THE CONTEXT

The Setting

Atlantic County has faced a multitude of social problems, including escalating numbers of homeless individuals and families, unsupervised street-bound youth, drug and alcohol abuse among youth, and a high incidence of teenage pregnancy and sexually transmitted diseases. Atlantic City, a municipality of Atlantic County, is disproportionately affected by these problems. Blacks and Hispanics are disproportionately represented in the problems that plague the county. The target population of the HIV Risk-Reduction Project was Black youth between the ages of 12 and 18 who had been identified as street bound and involved in high-risk behaviors in Atlantic County. Particular emphasis was placed on the Atlantic City Family Housing Projects, which are largely occupied by Black youth.

At the time that BAA began, the housing projects were drug havens where large numbers of youth/young adults congregated. Major characteristics were crowding, tension, violence, and large numbers of unsupervised minority youth who were involved in behaviors that placed them at risk for contracting HIV infection and other sexually transmitted diseases. The target population was at risk for intravenous drug/crack/cocaine use and prenatal/perinatal HIV transmission.

Youth within the Atlantic County area who were involved in high-risk behaviors were often alienated socially from the mainstream population. Often they did not receive needed health care services from conventional agencies/organizations because services were offered from operating bases that the youth found too controlled and/or alienating, e.g., schools, workshops, and health institutions. A major block to the provision of effective outreach services to the target population was the unwillingness of many conventional agencies to take needed services directly to certain areas of the

city that contain a large number of street-bound youth who were involved in **high-risk behaviors**.

Atlantic County is highly politicized, as are all local jurisdictions in New Jersey. Very little gets done without the involvement of the political, religious, and community-based leaders. The controlling institutions for all HIV/AIDS funding, past and present, are the Atlantic City Medical Center and the South Jersey AIDS Alliance (SJAA). An organization like BAA was necessary because minorities were not involved in deciding how Federal, state, and local HIV/AIDS funds were used and shared. The OMH grant was BAA's way of overcoming this barrier. At the time BAA was initiated, available HIV/AIDS funds and programs targeted the White gay community. A recent change in the hospital administration has created an atmosphere for improving the situation. However, there are few obvious and tangible changes to date.

Health Status

In New Jersey, Blacks make up 53 percent of the total reported AIDS cases, yet are only 12 percent of the total population. Hispanics comprise 13 percent of the AIDS cases, but only represent six percent of the population. In Atlantic County, Blacks comprise 18 percent of the population, and Hispanics comprise nine percent. There were a total of 130 reported cases of AIDS in Atlantic County as of May 31, 1989. Blacks represented 35 percent of the cases and Hispanics represented eight percent.

Despite statistical evidence that heterosexual Blacks and Hispanics are disproportionately at risk for contracting HIV, many still cling to the original perception **that** AIDS is a "white gay male disease." Some have broadened this original perception to include intravenous drug abusers (IVDA). However, they have not personalized the HIV/AIDS epidemic to include themselves to be potentially at risk.

II. PROJECT INITIATION

Antecedents

BAA was founded in Atlantic City, New Jersey in 1987 by a group of concerned Black and Hispanic health care workers, community leaders, and citizens in response to the high prevalence of HIV/AIDS among minorities in New Jersey. The organizational structure of BAA has its origins in the concept of community membership: to be run by the people for the people. Membership is composed of approximately 50 percent professionals in law, psychology, maternal-child nursing, and social work, and 50 percent lay persons. BAA has demonstrated its commitment to take the AIDS prevention message directly to the target community.

The purpose of BAA is to promote the structural integrity of the minority community by providing minority-sensitive education, skilled support, and a comprehensive resource

base to individuals, families, and communities in Atlantic County in an effort to combat the spread of AIDS. The impetus for this project was the need for funds to develop and implement HIV risk-reduction outreach services in the Atlantic City Black community. This project complemented existing BAA HIV/AIDS educational services.

Before OMH funding, BAA had been involved in various outreach and educational activities related to AIDS education and prevention among Blacks and Hispanics in Atlantic County. These included the development and pilot study of an assessment tool designed to measure baseline knowledge levels, attitudes, and behaviors among minorities. The tool was piloted by the Atlantic City Health Department among minority adolescents and young adults attending the prenatal and STD programs. BAA mass produced and distributed minority-sensitive pamphlets and posters.

Design

Baseline knowledge, attitudes, and behaviors in relation to HIV transmission/prevention among Black youth/young adults in Atlantic County were determined by using a culturally sensitive assessment instrument that was previously developed by BAA. The instrument was pretested in the Atlantic City Health Department's obstetrical and STD program among eight Black and two Hispanic youth. A Knowledge, Attitudes, and Behaviors (KAB) survey among 74 Black youth between the ages of 12 and 18 in Atlantic County was conducted in March 1990, six months after the project started. Findings from this survey were used to develop educational/outreach strategies to be responsive to the needs of the target population.

Project Goals and Objectives

Goal: To enable Black youth/young adults to reduce their chances of contracting HIV infection and consequently transmitting HIV prenatally or perinatally by providing them culturally-sensitive information on risk-reduction behaviors.

Objectives:

1. Develop a culturally-sensitive street outreach program based on prevalent knowledge levels, attitudes, and behaviors among Black youth in Atlantic County within eight months of funding.
2. Ensure that involved youth will be able to identify their risk behaviors for HIV infection during the program.
3. Ensure that involved youth will be able to identify at least two ways they plan to reduce their risk of contracting HIV and other **STDs** during the program.

4. Ensure that involved youth will demonstrate a willingness to accept and use educational materials/referral coupons for service during the program.
5. Provide street-bound youth with access to a comprehensive range of concrete services through organizational and referral resources within 12 months from the beginning of grant funding.
6. Identify, recruit, and initiate training of Black youth/young adults in Atlantic County to provide risk-reduction workshops to peers within 24 months of funding.
7. Conduct at least 20 home-based workshops annually, within 36 months of funding.

The principle intervention strategies used by the project were the operation of a “storefront” outreach facility within the target community; direct street education outreach; and peer-initiated home-based workshops. The project had three full-time staff (all African American), including the project director who coordinated the various components of the HIV Risk Reduction Project as specified in the proposal. She oversaw personnel operations and training, ensured the establishment and implementation of program policies, and was accountable to the BAA Executive Board. The street outreach educator provided HIV risk-reduction education and informal counseling services on the street. She also assisted with providing outreach services to youth at the storefront office. The project also had a secretary who provided clerical services.

The state’s train-the-trainer project was used by BAA to train staff and volunteers to conduct street outreach. An accountant and a lawyer were hired on an as-needed basis to audit the project finances and assist with the incorporation process. Initially, some individuals appointed to the board were quite enthusiastic, but tended to become less active as work to be done was specified. BAA received \$49,972 from the U.S. Conference of Mayors in the first year of the OMH project, and they used it to expand project services. The U.S. Conference of Mayors also provided necessary technical assistance during the early stages of the project.

Cultural Appropriateness

The language used to convey oral or written information to the target population was made understandable to a broad cross-section of minority youth, and was geared to a fifth-grade reading level. Approaches used to break down sociocultural barriers to HIV/AIDS prevention messages included education and counseling services-provided at easily accessible community locations, e.g. in a storefront office and homes. Project staff and volunteers at the BAA office included young people who canvassed

neighborhoods and housing projects three to four times a week and provided condoms and HIV/AIDS educational materials.

Evaluation Plan

An evaluation system was designed to measure the achievement of organizational process and outcome objectives. Progress toward the achievement of specified goals and objectives was documented on a comprehensive activity flow sheet before the conclusion of each work day. The project director prepared weekly summary reports and held monthly personnel meetings to discuss the project's progress toward achieving specific objectives.

Through pre- and post-test techniques, project staff assessed changes in HIV/AIDS knowledge and determined that the target population's lack of HIV/AIDS knowledge was not the main problem. Therefore, the project focused on effecting a change in attitudes and behavior among the target population. Attitudinal changes were measured indirectly by monitoring the demonstrated willingness of program participants to accept/use educational and/or referral coupons for services. Behavioral changes were measured indirectly by evaluating the participants' behavioral intentions.

III. PROJECT IMPLEMENTATION

Cooperative agreements were made with other community agencies and organizations involved in the HIV/AIDS educational effort, including the Atlantic City Health Department and the Salvation Army. The Health Department provided HIV testing and counseling services to clients referred by BAA staff. The project received brochures and literature from the city health department and in-kind donations, including office furniture, two copy machines, and one computer from the Casino Association, Boys and Girls Club, and NMAC/Apple Computers. A grant from the U.S. Conference of Mayors enabled the project to purchase recreational equipment suggested by the youth to make the office more youth-friendly. It also enhanced the project by allowing staff and community services to be increased. USCOM funding enabled BAA to offer employment opportunities to youth initially. The project also received financial and in-kind support from the New Jersey Department of Health Women in AIDS Program, United Way, private corporations, and community groups. The latter included local churches, although local churches were reluctant to get involved. The project also organized fund-raising activities and sold red ribbons, pins, and t-shirts.

BAA staff also completed the knowledge and attitude sections as part of their orientation. Pre- and post-tests were administered to home-based workshop participants. Following the HIV risk-reduction presentation, group activities included answering questions, group discussion, and using flash cards to determine group knowledge.

Most of the educational materials used by the project were obtained from national agencies. BAA also purchased culturally-sensitive literature from various AIDS service agencies. The project also designed a pamphlet and its logo which the Casino Association of New Jersey provided funds for typesetting and printing. A panel of advisory board members and youth voted on the appropriateness of materials before they were disseminated. The BAA Executive Board was expected to play a key role in project decision-making and fund-raising, and there was much enthusiasm at the beginning of the project. As problems arose, however, members did not follow through or did not participate at all.

Twenty youth volunteers were recruited and trained to conduct home-based workshops and street outreach. The workshops used visual and experiential learning techniques and included sessions on the identification of risk factors, risk-reduction strategies, STDs, substance abuse, life style choices, and other issues of sexuality. The volunteers did street outreach and passed out HIV/AIDS information at special events such as health fairs.

One of the challenges of street outreach was eliciting and documenting people's sexual contacts without making them uncomfortable. Contact cards were developed by the project that were small enough not to draw attention, could be completed immediately afterwards, and captured the essential information about the contact, as well as the verbal exchange with the outreach worker. BAA staff were also involved in multiple radio and television interviews, wrote newspaper articles, and made presentations in schools, colleges/universities, and local churches. Home-based workshop attenders who completed the pre-/post-test participated in a drawing to win a prize at the end of the workshop.

IV. PROJECT OUTCOMES

Achievement of Project Objectives

According to the project's final report, BAA implemented approximately 90 percent of the overall proposed objectives during the project period.

Objectives 1-4 were accomplished at a rate of 100 percent as of the fourth quarter of year three. During year three, BAA focused attention on accomplishing objectives five, six, and seven at rates of 85 percent, 90 percent and 50 percent, respectively.

Eighty-three percent of the home-based workshop participants completed both the pre- and post-test. Mean test scores were 75 percent and 82 percent, respectively. Program participant evaluation of home-based workshop presentations yielded a group mean score of 94 percent. BAA distributed 48,679 pieces of HIV/AIDS literature and 15,959 condoms during outreach activities.

Educational strategies were developed based on the KAB survey of 74 Black youth that was conducted in the Atlantic City Health Department in March 1990. The overall mean score was 58 percent. The mean scores were as follows: knowledge, 74 percent; attitudes, 46 percent; and behaviors, 62 percent. The project focused on attitudinal and behavioral changes within the target population.

Two adult and three youth outreach workers provided risk-reduction education on the streets of Atlantic City to 15,009 youth/young adults (direct street outreach: 13,190; ten home-based workshops: 116; and storefront activities: 1,703). This represents three times as many individuals as originally proposed. More than 90 percent of those contacted were receptive to offers of literature and condoms, and they indicated an intent to increase their knowledge of condom use.

The storefront office became more attractive and its use increased after the project convened a meeting of youth to obtain their ideas. They suggested putting up posters of contemporary entertainers/rappers and Black leaders such as Dr. Martin Luther King, Jr. and Elijah Muhammad. They also wanted posters on HIV/AIDS. The youth suggested games, playing records, videos, movies, arts and crafts, game tables, and board games. BAA made a good faith effort to implement at least 50 percent of their recommendations. The youth considered the storefront office as their own, or "their turf," and made full use of it during the project period.

BAA reported that 16 youth requested information on HIV/AIDS testing, but it was not known whether or not these individuals actually took the test, as it is difficult to track referrals through anonymous testing. Before this project, street outreach was not viewed favorably by the health care agencies. However, as HIV/AIDS funds became available, this strategy increased in popularity among service providers.

Influence on Providers/System

The general consensus among local service providers was that BAA served as a wake-up call to mainstream HIV/AIDS providers that, in view of the magnitude of HIV/AIDS infection among this population, the Black community was not receiving its share of HIV/AIDS dollars or educational and preventive services. However, it was also their perception that BAA was too militant and uncompromising in its approach and had the tendency to alienate potential collaborators. In their view, a balance was not achieved during the project period.

Project Continuation

BAA submitted requests for funding to various corporations and foundations during and after the extended project period. Plans were developed to initiate a formal fundraising program to ensure that short-term and long-term goals and objectives were achieved, but these efforts did not achieve a level of funding sufficient to continue the

program. During the fundraising campaign, BAA was able to attract funding from several local churches and from major drug companies, e.g., Burroughs Wellcome, Bristol Myers Squibb, Abbott Laboratories. Also, the project director and the volunteer coordinator continued to provide educational services on a voluntary basis for over a year after the OMH grant ended. Funds obtained through local fundraising helped to make this possible. BAA has received many requests for information on its HIV/AIDS project including, program/organizational development and outreach materials. These requests have come from other states and from Canada and Africa.

The project ceased all levels of operation in December 1993. BAA still occupies the storefront office, but it is locked. The owners of the building have not yet taken action to collect rent or reoccupy the space. The president of the BAA Board indicated that very few Board members are now active, and that those who are seem reluctant to take any action.

Unanticipated Outcomes

- **BAA** was the first to address the problem of HIV/AIDS in the Black community in Atlantic County. This has led to a greater sensitivity toward minority issues among mainstream health service providers. Some are now beginning to do outreach in minority communities.
- The South Jersey AIDS Alliance has increased minority representation among staff and volunteers.
- The project's volunteer coordinator was inspired to pursue a college education as a result of her experience with the project. She is the first among her siblings to do so.
- BAA and the project are recognized outside Atlantic County. The project director receives numerous invitations to participate in HIV/AIDS workshops, particularly those that relate to adolescent issues.

V. LESSONS LEARNED AND SUGGESTIONS

Lessons Learned

- According to the BAA Board president, the Black community, in general, still denies that an HIV/AIDS problem exists. He feels that the community does not understand the goals and objectives of BAA.
- According to the project director, a strong, working Board of Directors is needed to provide comprehensive program planning and to assure the continuation of agency programs.

- The minimum staff needed to run this kind of program is a full-time project director, two adult outreach workers, two youth outreach workers, a part-time volunteer coordinator, and an administrative secretary.
- At least a \$100,000 annual budget is required to accomplish objectives and targets similar to the HIV Risk Reduction Among Atlantic County Black Youth Project.
- Use of the storefront office dramatically increased after a youth meeting during which they were given the opportunity to make suggestions on how it should be decorated and what kinds of activities would interest them.
- It was very difficult to motivate youth volunteers to conduct home-based workshops after training. Monetary incentives may be necessary.
- It is helpful for a project of this nature to involve and obtain the cooperation and collaboration of state and community-based political leaders even if they do not provide initial funding.

Suggestions for Project Improvement

- Inform and involve state and local leaders at all stages of the project.
- If possible, identify a teenager with HIV or AIDS who will be willing to talk to his peers about HIV/AIDS prevention.
- Train Hispanic or Spanish-speaking peer educators and involve them in outreach activities.

Suggestions for OMH

- Provide \$150,000 annual funding for a period of at least five years, with the condition that the project demonstrates viability after the first three years.
- Provide technical assistance for grant management and problem resolution during the funding period.
- Non-educational areas of HIV/AIDS support should include case management, support groups, and housing.

PROJECT CASE STUDY

Haitian Coalition on AIDS Brooklyn NY

In 1988, OMH made a three-year HIV/AIDS Education/Prevention grant award for the Haitian Coalition on AIDS through the Haitian Centers Council in Brooklyn, New York, to establish innovative approaches to educating Haitians and Haitian Americans about AIDS and HIV infection. The project focused on the use of radio and television in a variety of formats to reach the target population.

I. THE CONTEXT

The Setting

The Haitian population in New York City and the metropolitan area is estimated to be 450,000 persons. It is considered to be one of the most impoverished and underserved groups in the entire city. The Haitian community is comprised of three main groups. The largest group is recent immigrants whose economic life can be described as subsistence level at best, as they struggle with minimum wage income to maintain themselves and their families. The second group is immigrants who immigrated in the 1960s and who have dispersed into Queens and Brooklyn. The smallest group is composed of youth and the children of Haitian immigrants. Most Haitians speak Creole; only about 20 percent speak French.

Health Status

It is estimated that two percent of the AIDS cases in New York occur among Haitians. However, Down State Medical Center of the State University of New York reports that 5.9 percent of the children born to Haitian parents are seropositive and six percent of the general population of Haitians who visit the hospital are HIV positive when tested. Kings County Hospital Center is a municipal hospital located in Brooklyn, NY, and is the primary health care facility for the vast majority of all Brooklyn residents who have AIDS. The Haitian Coalition on AIDS maintains an office at Kings County Hospital and works closely with the hospital's Social Work Department in an effort to provide support services to the Haitian AIDS patient and his or her family. Through its sponsored health fairs, workshops and Creole/French hotline, the Coalition also has established links with persons vulnerable to AIDS.

II. PROJECT INITIATION

Antecedents

The Haitian Coalition on AIDS was created in January 1983 and initial funding was provided by the New York State Department of Health (DOH). The Coalition is an outgrowth of common efforts on the part of several concerned Haitian groups, including the Haitian Centers Council (HCC), Association of Haitian Physicians Abroad, Association of Haitian Social Workers, and the Haitian American Legal Defense Education Fund. The OMH grant application, which was submitted by the Coalition through the HCC, proposed the establishment of innovative approaches to educating Haitians and Haitian Americans about AIDS and HIV infection.

HCC, a non-profit organization, was created in June 1982, at the height of the Haitian refugee problems. HCC's mission was to inform public opinion about issues that concern Haitian communities in the United States. HCC acts as the coordinating body linking the activities and efforts of eight Haitian Centers in the New York City area. Some of these centers have been in existence for over 26 years. HCC serves as advisor, fund raiser, administrator, advocate, and speaker organization for the eight centers. Each of the centers has its own Board of Directors, and the directors of the centers form the advisory board of HCC. All are working primarily to help Haitian immigrants establish themselves in the United States, although services are also offered to the public at large.

At the time of the OMH grant, the HCC had established credibility and involvement in AIDS activities within the Haitian community and had extensive linkages with hospitals and other agencies in the New York City (NYC) area, including The Brooklyn Ralph and Good Shepherd Center, the Brooklyn-based Evangelical Crusade, the Charlemagne Peralte Center in Brooklyn; the Haitian Neighborhood Service Center in Manhattan; the Haitian American Cultural and Social Organization in Spring Valley; and the Haitian Americans United for Progress organization in Queens.

HCC's services include educating clients about HIV/AIDS as well as organizing remedial educational programs (English as a second language, adult literacy, and preparation for high school equivalency exam); providing a forum and informational center for charitable, educational and social welfare agencies; providing limited financial and other support within the resources of HCC; serving as an advocate for the Haitian community, including counseling and advice on entitlements (Medicare, food stamps, welfare, and social security); supporting relevant legislative initiatives; organizing Haitian folk dance and fine arts programs; and doing any and all things deemed necessary to accomplish the mission of the Council. HCC has established a very strong and supportive network with government health facilities, social services agencies, and the media to carry out its mission.

Design

The purpose of the Haitian Coalition on AIDS Project was to use radio and television to increase the awareness of the risks of AIDS and AIDS-related complex among Haitians living in the five boroughs of New York City, as well as those in upstate New York, Long Island, New Jersey, and parts of Connecticut and Pennsylvania.

Radio and TV broadcasts were to be made in Creole. A variety of broadcast formats were to be used, including group and panel discussion, drama, interviews with service providers, 20 and 30-second spots, a one-hour talk show, and panel talk shows. Additionally, an HIV/AIDS hotline was to be established, and personnel staffing the hotline were able to communicate with people who spoke either Creole, French, Spanish or English.

Project Goals and Objectives

The project's goal was to use electronic media (radio and television) as a means to increase awareness and provide HIV/AIDS education to the Haitian community in the project area.

Project objectives were to:

1. Reach the following number of people in the target population during the indicated years:

	<u>Radio</u>	<u>TV</u>
1st Year	20-30,000	2530,000
2nd Year	30-40,000	40-50,000
3rd Year	75-90,000	90-1 20,000

2. Produce the following number of 30-minute radio programs and 15-minute TV shows every week during the indicated years:

	<u>Radio Ginen</u>	<u>TV</u>	
	<u>RKG 126</u>	<u>Ch44</u>	<u>Ch47</u>
1st Year	36	26	26
2nd Year	48	52	26
3rd Year	50	52	26

3. Establish an AIDS hotline and receive the following number of calls during the years indicated:

<u>Number of Anticipated Calls</u>	
1st Year	500
2nd Year	2,500
3rd Year	3,500

The project objectives were expanded during the third quarter of year two and included the following:

1. To work with service providers in improving the service system for the care of Creole-speaking patients with HIV/AIDS.
2. To assist people with AIDS from the target areas in obtaining education, financial assistance, shelter, and immigration services as these needs arose.
3. To disseminate more educational health information regarding HIV/AIDS.
4. To assist other service providers who want to gain knowledge about the Haitian culture and language, thus allowing them to be more sensitive to those people with AIDS.

Cultural Appropriateness

The strategies used to make the educational programs culturally appropriate were: (1) presentation and broadcast of information in Creole, the language spoken by all Haitians; (2) the use of Haitian educators; (3) emphasis on electronic rather than print media in view of the low literacy rate of the target population; (4) a telephone hotline which preserved the anonymity of the callers; and (5) the use of existing Haitian institutions and electronic media known by the target population.

Evaluation Plan

The Haitian Coalition on AIDS planned to test the effectiveness of radio versus television programs by:

1. Announcing a hotline number at the end of each radio and television program and asking viewers to call with questions and comments.
2. Using a questionnaire to survey callers about the impact of the AIDS programs and spot announcements.
3. Generating statistics on the number of calls, types of comments and questions, in addition to pertinent demographic data on each caller's gender and age.
4. Following each radio program with an immediate live discussion with the public for questions and answers, probes, and interviews.

Kings County Hospital conducted a study of HIV seropositive rates, knowledge,

attitudes and practices among Haitian patients, which served as the baseline for the project.

III. PROJECT IMPLEMENTATION

The project had two staff members, a project director (15 percent time) and an administrative assistant (10 percent time), both of whom were Haitian. Consultants were used to produce the radio and TV programs and the spot announcements in Creole. Additional staff was added during year two, a health educator (10 percent time), and two counselors (10 percent time each).

As stated earlier, this project primarily used the electronic media to increase HIV/AIDS awareness among the target population. Listeners were encouraged and given the opportunity to call during the radio programs and to call the hotline after a TV program to ask questions and make comments about what was discussed. Pertinent information about HIV/AIDS service providers and testing sites were given during radio and TV broadcasts.

A Haitian TV production company was paid to produce the TV programs. However, the amount was far short of total production costs and airtime. The producer made substantial financial and in-kind donations to keep the programs on the air during the project period. In most cases, guests presenters and panelists volunteered their time for both radio and TV programs.

The project took advantage of links within the close-knit Haitian community. For example, those between the participating Centers and Haitian staff members of health and social service provider organizations such as the City of New York Division of AIDS Services (DAS) were used to reinforce broadcast messages and to link listeners to HIV/AIDS services.

To the Haitian community in general, AIDS is not only a medical issue but a highly political one as well. During the beginning of the epidemic, it was stated in the media that Haitians were the major source of infection in the United States. In seeking to dispel that myth and educate the public, the Haitian -medical community as well as the project health educator were severely criticized by the Haitian citizens for raising the alarm about HIV/AIDS infection in their community. One physician who was also a HCC board member, indicated that his office was picketed by Haitian protesters during the initial stages of the project. Over time, however, as the project developed, relations between the project staff and the community improved.

The fact that the Food and Drug Administration (FDA) announced in 1990 that blood donations would no longer be accepted from Haitians greatly exacerbated the situation. The project staff and professional volunteers were accused of aligning

themselves with the “oppressor.” This action contributed immensely to unifying the Haitian community and focusing attention on the HIV/AIDS problem. The Haitian leadership at all levels organized a massive march of mostly Haitian people (estimates range from 50,000 to 250,000 people) across the Brooklyn Bridge in April 1990 to protest the FDA’s directive and demand its reversal. HCC, the Haitian Coalition on AIDS project director, and the project’s health educator played key roles in organizing the march. This was the first march of such magnitude across the Brooklyn Bridge. The FDA finally rescinded the directive, it is believed, as a result of this march and protest.

Another key event that occurred toward the end of the project was an interview on the project’s TV program with a very popular Haitian musician, Yvon Louissaint, who at the time had AIDS. He has since died. This helped to make inroads into the denial that still plagues the Haitian community. Mr. Louissaint shared his pain of being disowned by his family and gave good advice to all people about HIV/AIDS prevention and people with AIDS. At the end of the interview the project’s health educator, a physician, hugged Mr. Louissaint. She received a number of favorable comments from her viewers about the hug: it made an impact on the viewers, and it may have dispelled many of the myths about how HIV/AIDS is spread.

One aspect of Haitian culture that presented — and still presents — a challenge to HIV/AIDS education and project implementation are Haitian notions of privacy. Individuals will take whatever steps are necessary to keep others, in some cases even family members, from knowing their personal business. This may help explain why the electronic media was the appropriate medium for the target audience. Radio call-in programs and the hotline allowed individuals to seek information anonymously. Because of project staffs knowledge of the Haitian community, they recognized the importance of ensuring that HIV/AIDS information, testing sites, and medical services were available with Haitian service providers in confidential settings. This was demonstrated during the project, and included the availability of services across town from where a person lived, or connecting with another Haitian outside one’s immediate community.

Throughout the project period and beyond, interest in HIV/AIDS education and prevention has been overshadowed by interest in the local elections in Haiti, the plight of the boat people, and the U.S. Government’s position on repatriation.

IV. PROJECT OUTCOMES

Achievement of Project Objectives

The Haitian community’s response to the projects efforts were reported to be extremely positive. According to the final project report, all radio and TV program production targets, except the second year, were exceeded. The TV production

company and Channel 47 estimated that the programs reached 10-15 percent of the target audience. RKG 126 Radio estimated that the New York City audience was between 60,000 and 70,000 in 1990, based on responses received after each Monday evening show. After a program was aired, individuals called the radio station, the HCC's office, the TV production company, and the health educator at home to request more details. In most cases they demanded to speak to the health educator, who has cultivated a "media personality" in the past few years. Some callers felt that their question could not be answered by anyone other than "the doctor who talks about AIDS." While on-air, she successfully, and necessarily, discussed every aspect of HIV and AIDS, and often collaborated with other community leaders. For example, the Monsignor of a local Catholic church appeared on her radio and TV programs, supporting the HCC's efforts and answering questions. The radio show continues to be aired.

Influence on Providers/System

The project listed the following as major accomplishments:

- The community has developed a keen sense of awareness as demonstrated in its active participation in the radio talk shows and in the TV call-in programs.
- Many people, including people in adjacent states, have called the hotline after viewing the TV show to ask questions about the show or to request other needed information.
- More teens have expressed their concerns about their vulnerability as demonstrated in the HCC's involvement in local schools. Teens are asking questions that indicate they are trying to understand how the HIV virus is or is not transmitted, thus showing their willingness to make decisions based on facts.
- The number of calls from the hotline have increased tremendously throughout the project period and beyond. Calls are consistently received after Sunday TV shows are aired, and after Monday radio talk shows.
- HCC has received many referrals from service providers and other professionals in the NYC area since starting its information/education campaign, resulting in collaboration with other organizations. For example, HCC developed a technical assistance workshop together with the AIDS Institute for Professional Civil Surgeons.

From the very beginning of HCC's AIDS education project, it appeared that the network of Haitian organizations was strengthened. However, most respondents feel that there is still a strong need for the awareness-raising and education that the project

has provided to the Haitian community. A network of concerned Haitians and other NYC residents rallied together again to try to get the present mayor of New York City to reverse his decision to integrate the DAS into larger city social service agencies. Most people in the area (Haitians and non-Haitians) feel that this will result in fewer direct services for people with AIDS in general, and fewer services delivered by workers who speak Creole, who care as deeply about the client, and who are sensitive to cultural differences, in particular.

Project Continuation

The Haitian Coalition on AIDS continues under the direction of the health educator. She is assisted by two counselors who do outreach education. The radio and TV programs do not have a regular schedule, but they are now produced and aired as funds become available, or when there is an HIV/AIDS issue of which the community should be made aware, e.g., the dissolution of the NYC Division of AIDS Services (DAS).

Since the end of the OMH grant, the project has been unable to attract funding to continue the media campaign. The health educator at HCC is still active in AIDS education, and HCC has expanded its services to include comprehensive case management, outreach worker training, educational outreach (including outreach to a local high school with a substantial number of Haitian students), counseling, and emergency funding. HCC will soon be involved in trying to obtain temporary housing for people with AIDS. These programs are supported by the City of New York, Title I, and Ryan White funds, but competition for resources and the threat of reduction of AIDS services always looms ahead for CBOs in the NYC area that struggle to provide comprehensive care. Some of the Haitian organizations that are part of HCC have initiated HIV/AIDS educational programs with their own resources, but they primarily depend on HCC to provide either the spectrum of services, or the network HCC has cultivated to connect people with AIDS with services.

V. LESSONS LEARNED AND SUGGESTIONS

Lessons Learned

- Despite the project's best efforts, the level of denial among Haitians about HIV/AIDS is still very high.
- Unity of purpose means strength. It is incumbent upon Haitian organizations to act together to address issues that affect their community. It is believed that once people are seriously dedicated to a cause, it is possible to move mountains.

- It is possible to find people who are willing to help, as long as you show you are committed.
- HCC's experience confirmed that the electronic media can be a very appropriate medium for the Haitian community. Media programs are more acceptable and effective if they include the human touch, are not condescending, include elements of humor or stories, and are anonymous.
- There are cultural barriers in electronic media programming. It is important to be very clear on what is and what is not appropriate to say for a particular audience. One must always be conscious of the cultural boundaries and beliefs of the community to be addressed.
- In the Haitian community, women who discuss issues related to sex in a public forum will be challenged. On one occasion, the health educator involved a religious leader in the discussion of AIDS-related topics. This action addressed anticipated questions, and sustained her credibility within the community.
- The Haitian community is less likely than other communities to attend a public discussion on AIDS because of cultural barriers, such as issues of privacy and discomfort about open discussions of sex.
- It is the projects experience that HIV/AIDS is more than a health problem. People living with HIV/AIDS and their families and loved ones have multiple needs that must be addressed. Organizations that take on the responsibility of caring for people infected and affected by AIDS must be able to provide comprehensive health and social services. In this case, staff feel that their job with the project represents a personal responsibility and a moral obligation to provide HIV/AIDS services to their community.
- Frequently, there are rich sources of non-traditional data that could be reviewed and used for educational and other purposes. For example, the head nurse in the Queens Hospital HIV/AIDS clinic has kept detailed hand-written records on each patient seen at Queens Hospital clinic since 1985. If the clinic had access to a computer, these data could have been used in the project.

Suggestions for Project Improvement

- Technical assistance is needed during the initial stages of projects to help design and establish protocols for evaluation.
- A greater proportion of funds are needed for radio and TV production and airtime when sponsoring a media campaign. TV time is not affordable for most

CBOs, and media campaigns require a long-term commitment from station owners and operators.

- Affordable housing is a great need for people with AIDS.
- Other target audiences in the Haitian community who would benefit from HIV/AIDS outreach and education include teenagers and undocumented people. Both have special needs that are not being fully met.
- A general fund needs to be established for social support and for burials for those living and dying with HIV/AIDS.

Suggestions for OMH

- OMH should fund demonstrably successful projects beyond the initial three-year period.
- Grants for media-focussed projects should be increased to \$200,000 per year.
- OMH should use the expertise of independent consultants and/or companies to provide technical assistance to projects, to conduct needs assessment, and advise OMH on which projects deserve continued support among those that are evaluated.
- OMH should coordinate assistance to CBOs with other Federal departments to address needs.

PROJECTCASESTUDY

South Texas AIDS Education For Mexican Americans San Antonio TX

In 1988, OMH made a three-year HIV/AIDS Education/Prevention grant to the Hispanic AIDS Committee (HAC) to provide a comprehensive AIDS education and prevention project for sexually active Mexicans and Mexican Americans in South Texas. The South Texas AIDS Education for Mexican Americans Project components included the development of culturally sensitive educational materials in bilingual formats and the implementation of a home education program for Hispanic adults.

I. THE CONTEXT

The Setting

San Antonio and surrounding counties were targeted for this project. The city's population is approximately 65 percent Hispanic, most of whom (approximately 95 percent) are Mexican and Mexican American. The Mexican and Mexican American community is highly diverse in terms of levels of acculturation, language skills, educational levels, and economic status, thereby making appropriate education a challenge for AIDS educators and health care providers.

Health Status

The total number of reported AIDS cases increased from 274 in 1988 to 1,947 in **1994**. **Of the total reported** AIDS cases in Bexar County between 1981-1994, 43 percent were among Hispanics. High risk behaviors of adults and teens in San Antonio include unprotected sex, multiple sexual partners, intravenous drug use and substance abuse, and unsafe use of needles (e.g., tattooing, sharing for insulin injections). At the time of the OMH project, there were no formal services through the city/county health department for Hispanic people in San Antonio.

II. PROJECT INITIATION

Antecedents

HAC was organized as an advisory board in 1987 by a group of concerned San Antonio professionals representing all sections of the health, business, education, arts, and service communities. The Hispanic AIDS Committee (formerly the Hispanic AIDS Committee for Education and Resources - HACER; in Spanish it means, "to do, to make") is a private, non-profit organization established to educate the minority

communities in Texas about the threat of HIV and related issues that jeopardize minority community health, and to provide direct services, including counseling, support, financial assistance, and temporary housing to HIV-infected persons.

HAC started community AIDS education in San Antonio in 1987 with funds from the U.S. Conference of Mayors and the Texas State Department of Health. At the time of the OMH project, there were still very few Spanish language materials or prevention and outreach services addressing AIDS prevention in the Hispanic community.

Design

The purpose of the project was to provide a comprehensive AIDS education and prevention project developed for the Mexican/Mexican American population in South Texas. HAC's plan was to develop culturally sensitive educational materials in bilingual formats (English and Spanish on adjoining pages), as well as videos, photonovellas, comic books, and audio cassettes that would educate this segment of the population using an appropriate educational and social level. A second major element of HAC's plan was to implement a home education program for adult Hispanics. In an initial review of HAC's objectives, it was determined that the project could best serve the city of San Antonio only. The project then targeted a number of the city's housing projects to make initial door-to-door contact with Mexican and Mexican American residents to assess their level of AIDS knowledge and to determine their receptivity to the conduct of focus group sessions in their homes. Using its knowledge of and contacts in the Mexican American community, HAC staff began to design and produce a range of culturally-appropriate educational materials to accompany outreach and client services.

Project Objectives

Specifically, project objectives were to:

- Conduct Hispanic home discussion groups to provide AIDS education and risk reduction to sexually-active Hispanic persons.
- Review existing materials and develop new, culturally-appropriate AIDS educational materials.
- Train volunteers and provide materials for outreach to rural communities.
- Expand current outreach efforts of community education presentations to other sites within the targeted community.

Cultural Appropriateness

The project used trained, bilingual, bicultural educators to conduct outreach and educational sessions with the target population. Materials used for distribution were either reviewed for appropriate content and language, or designed with the target audience in mind. Outreach by staff and volunteers to the community was flexible in planning locations and times convenient to the client. HAC also made efforts to evaluate their interventions and receive feedback from the target community about intervention methods and educational materials.

Evaluation Plan

As part of its project evaluation, HAC maintained logs and files of contacts, materials in use, training sessions, evaluation responses, and recommendations made for the project by clients, staff, and Board members. The project evaluated each intervention through the use of evaluation forms and surveys, including a demographic assessment of participants, pre- and post-tests of home discussion groups, assessments by participants in the program, and follow-up assessments made by focus group participants.

III. PROJECT IMPLEMENTATION

After advertising the program through word-of-mouth and door-to-door solicitation, HAC staff arranged discussion groups, called “focus groups” in this project, at the request of individuals who agreed to host them. People hosting the presentations were asked to invite their relatives and friends to participate. To help sustain interest and participation, HAC would often bring refreshments for the group or provide condoms and AIDS education materials.

Home Focus Groups: The format of the presentation was structured to both inform and involve participants in the AIDS education curriculum. First, the presenter would determine what language (Spanish or English) the audience felt comfortable with for the topics to be covered. Additionally, although it was not always possible, HAC would try to have one male and one female together at presentations in order to put people at ease and to facilitate discussion. Second, a pre-test was given to the participants. A video was then shown, followed by a general AIDS face-to-face talk. Then participants split up into gender-specific small groups to talk in more detail about sex and AIDS. Question-and-answer periods were included throughout. The group was then brought back together and given a post-test. This approach had something for everyone, and proved effective in getting the message across and evoking discussion. Often, a presentation would prompt people to ask HAC presenters to return and give another presentation. For example, parents who wanted to inform their children about sex and AIDS could attend a presentation together while the message was being given.

Outreach Efforts: The project conducted AIDS education sessions at community, health, and social service organizations in and outside of San Antonio during the project period. HAC accomplished this objective with presentations at the county jail, community shelters, health centers, and other locations in addition to making home focus group visits.

Educational Materials: HAC created, produced, and modified education materials which specifically addressed the needs of the Mexican American community (a list of educational materials can be found at the end of this case study). In producing these materials, in-kind resources were an important component of this project. The advisory board lent its support at the outset of the OMH grant by helping with presentations. Its continuing duties involved reviewing educational materials for the project. The HAC director created and produced practically all educational materials developed for the organization. Radio spots, television spots, and photonovella pictures were performed for free by professional actors and local and regional celebrities. Finally, condoms were obtained at no cost from the state for distribution at presentations.

IV. PROJECT OUTCOMES

Achievement of Project Objectives

HAC exceeded the goals and objectives set forth in the OMH proposal. HAC demonstrated committed leadership and a great knowledge of the culture, people, and community served through this program. Such expertise and knowledge translated into effective cross-gender and intergenerational communication between educators and the audiences served, effective use of media and community networks, and the creation of culturally appropriate materials. AIDS educators from HAC spoke the language and shared the culture of the target population, which enabled them to relate, in a non-confrontational manner, to the target population's cultural conceptions of sexuality, religion, and interpersonal relationships. Posters designed by a HAC staff member were used in bar bathrooms and schools, while photonovellas and bilingual materials were tailored to jail populations and the general public. Likewise, videos produced by HAC proved to be a helpful introductory tool for home presentations.

The only obstacle in delivering services was despite trying to meet a high demand for AIDS education with only a limited number of people and dollars. The OMH grant enabled HAC to expand existing HIV/AIDS education/prevention services and to initiate an innovative and culturally-sensitive approach to raising the awareness of a targeted audience.

Influence on Providers/System

There has been, and remains, a lack of support for HIV services from the city of San Antonio, the city/county health department, the school system, and religious organizations in and around San Antonio. Further, CBOs rarely have access to greater Federal dollars available for HIV/AIDS education. However, HAC has been able to maximize available local resources by networking and forming a loose consortium with other local minority agencies and community organizations. For example, this alliance has resulted in HAC working with the local Black AIDS organization to provide services to the minority community. HAC has also expanded its services in response to the spread of the virus in the community and its related sociocultural implications.

Project Continuation

The project continued despite suffering a financial setback after the end of OMH funding. Services now include education, testing, counseling for HIV seropositive individuals, case management, a food pantry, limited financial assistance to individual clients, a resource center and information (including videos, television and radio spots, bilingual posters and brochures, photonovellas, and a bilingual dictionary of HIV terminology), a bilingual (English/Spanish) AIDS information telephone line, speaker's bureau (to address local groups, organizations, schools, and churches), and a 12-bed facility (Casa Martin) for HIV positive and/or homeless persons. Home focus groups are now sponsored by the CDC and include monetary incentives for participants. Project staff also continue to conduct scheduled visits to jails, shelters, and other community organizations in and outside of San Antonio.

HAC has created and produced a number of educational materials, produced copies, and sent them to various organizations, such as the National AIDS Clearinghouse and other HIV/AIDS organizations throughout the United States, Europe, and Central and South America.

HAC is working with Incarnate Word College in San Antonio to develop a curriculum to further expand the Home Focus Group. HAC is also working with the Mujeres (Women's) Project to continue the expansion of the Home Focus Group for women through a battered women's shelter.

Unanticipated Outcomes

- HAC has established a good local and national reputation. Locally, it is well known and respected, as well as being financially solvent. Nationally, staff have testified at two Federal hearings on AIDS; have been elected to the CDC Advisory Board on HIV, and actively participate in the National Hispanic/Latino AIDS Coalition.

- Educational materials produced by HAC are being replicated and used both nationally and internationally.
- HAC has expanded to be a full-service organization, providing education, counseling, case management, and testing to persons of all races and from all economic backgrounds. In the past seven years, the staff has grown from one person to 18.
- HAC now collaborates with the state health department for HIV antibody testing.

V. LESSONS LEARNED AND SUGGESTIONS

Lessons Learned

- “Experts” do not often have the same feeling or knowledge about a community that local people have. Project design should be based on what people know about their own community.
- Small incentives (such as cash, food, or coupons) are essential when engaging people to participate in AIDS education and prevention activities, especially if prevention takes place in someone’s home.
- Educators working with bilingual groups must be bilingual, must know or share the culture of the audience, and must be secure with themselves to effectively communicate AIDS prevention messages.
- The message is more effective if it is communicated with sincerity and tailored to the audience to whom it is being delivered. It is possible and necessary for educators to cross gender or generational barriers, provided they are flexible and non-threatening. Making the connection across these barriers can help to make the message more effective.
- It is possible to accomplish many things with little money, but a long-term struggle with finances strains and limits services.

Suggestions for Project Improvement

- CBOs should have greater flexibility than current regulations permit in allocating grant monies for specific purposes, such as employing staff personnel.

Suggestions for OMH

- OMH should strive to present itself as an organization representative of all racial/ethnic minority groups.
- Funds and time periods for OMH grant periods should be increased.
- OMH should take a greater role in soliciting materials from grantees that could be disseminated nationally for the same minority group, or across cultures.
- OMH should provide money (beyond project award) to **CBOs** to print and duplicate educational materials, or provide the service to **CBOs**.
- OMH should communicate more frequently and more effectively with **CBOs**. For example, OMH should let **CBOs** know what kind of additional or **post-project** funding is available, what kinds of technical assistance OMH has to offer, and what other dissemination and information services are available.
- OMH should give funding preference to organizations they have funded in the past who have demonstrated a positive impact and who have established a viable, needed, and effective program.

Educational Materials Produced by the Hispanic AIDS Committee:

** - Produced with OMH monies.

** Photonovella: "El Precio Del Engano" (The High Price of Cheating) written by Jesus M. Sanchez and Jose C. Hernandez.

Manual: HIV Education and Prevention for the Hispanic in the Home. By Jesus M. Sanchez, M.A., M.Th. and Josie N. Esquivel, R.N., B.S.N.

** "Straight Talk About AIDS...What Every Man Needs to Know." (in Spanish and English) By Jesus M. Sanchez, Jose C. Hernandez, and Martin De La Garza.

The San Antonio Handbook for HIV Positive Persons: Information, Resources, and Advice (adapted from the Louisiana Handbook for Persons with HIV/AIDS). y Enrique R. Salazar and Jesus M. Sanchez.

Bilingual AIDS: An English/Spanish Dictionary of HIV Terminology for Educators and Caregivers. By Jesus M. Sanchez and Martin De La Garza.

Proceedings of the First Southwest Regional Hispanic AIDS Conference. May 17-20, 1989. Copyright 1989 by HACER, conference funded by the Centers for Disease Control and Prevention and the Texas Department of Health, Division of AIDS and STD Control.

Videotape: "SIDA: Lo que toda persona debe **sabar**" (AIDS: What everyone needs to know). 30 minutes.

Photonovella: "La Mujer Marcada...La Tragedia de Una Mujer Moderna," (A Marked Woman). In Spanish and English. Produced by HACER, written by Jesus M. Sanchez and Jose C. Hernandez.

Posters: "Hablando Claro, Compadre," Spanish only. By Jesus M. Sanchez and Jose C Hernandez.

Rabbit Poster. In Spanish and English. By Jesus M. Sanchez.

C. Project Suggestions

Overview:

The following suggestions represent a distilled yet complete list of CBO project suggestions made to the evaluation team during data collection.

Activities supported by the OMH HIV/AIDS Education and Prevention grant were needed, and succeeded in reaching an underserved population. Grantees felt it important and necessary that OMH continues to support minority community-based projects and be willing to invest more time and resources in minority CBOs. Now that OMH has brought people “to the table,” it is important to sustain their involvement and/or offer continuing support and advocacy for those projects that it has helped along. Both sides will benefit from an on-going exchange, regardless of whether OMH is providing funding or not.

More than 50 percent (at least five projects) of CBOs involved in the evaluation study made the following suggestions to OMH to consider: greater annual funding for CBOs; continued funding for projects that have demonstrated success/viability; a greater emphasis on information exchange and feedback from OMH; and greater level of technical assistance for projects funded by OMH.

At least three projects made suggestions that OMH continue to fund CBOs directly, and projects suggested areas where future Federal funds could best be directed. The following provide more detail on these suggestions for Federal agencies and other grant-making entities:

1. Provide more money for community-based HIV/AIDS projects, and allow more time for grant activities. Specifically, OMH should provide between \$100,000 and \$200,000 annual funding for a period of at least five years with the condition that projects demonstrate viability after the first three years. Funding should adequately address the needs of the project, taking into consideration the number of persons needed to carry out grant activities and the geographic location of the target population.
2. Continue to provide grants directly to CBOs. The trend toward funding only CBO coalitions may adversely affect small CBOs that provide a needed service to an underserved population.
3. OMH should either: a) give funding preference to organizations they have funded in the past who have demonstrated a positive impact, and who have established a viable, needed, and effective program, or b) help past-funded programs provide technical assistance to other CBOs funded by OMH. This

may include identifying experienced and effective project managers and funding-related expenses.

4. Inform newly-funded programs of the successes and failures of previously funded programs, especially if there are any similarities in target group focus and strategies between new and former projects. This exchange of information should occur fairly early in the grant cycle, probably in the first three months. OMH should respond consistently and offer feedback on project reports throughout the grant period. Midway through the grant period, OMH should communicate frequently and effectively with CBOs by letting CBOs know what kind of additional and post-project funding is available, what kinds of technical assistance OMH has to offer, and what other dissemination and information services are available.
5. Provide technical assistance throughout the grant period to insure that the program has the best possible chance of accomplishing its objectives, particularly during critical stages of grant application, project development, implementation and evaluation. Specific areas identified by grantees for technical assistance include: using/managing CBO boards; grant writing; needs assessment; information systems management; expanding organizational capacity; problem resolution; and evaluation. Where feasible, take steps to identify and use local experts who can assist projects.

Require grantees to participate in this kind of cross-site program evaluation study. However, there should be a time limit on how long after the grant period that participation is required.

6. Consider using grant resources for the following two issues: development of effective education and prevention strategies for youth who are both infected and affected by HIV/AIDS; and raising awareness about the impact of alcohol, other drugs, and STDs, particularly, how they put individuals and families at risk for HIV/AIDS. Federal agencies should also concentrate on educational programs that adjust to and reflect the exigencies of the virus, e.g., public service announcements that focus on living with HIV/AIDS and how CBOs are serving those needs.
7. Coordinate CBO assistance with other Federal agencies to address non-educational needs: more appropriate and affordable health care and social services, especially treatment centers for indigent populations; female-focused interventions; case management; housing; and advocacy for patient rights concerning health issues.

8. Continue to hold annual grantee meetings to keep abreast of what former and current grantees are accomplishing, to update grantees on the latest HIV/AIDS information, and to facilitate networking between both groups.
9. OMH should continue to present itself as an advocate of all racial/ethnic minority groups. Further, OMH should ensure that underrepresented groups in racial/ethnic groups (e.g., Pacific Islanders) are represented when the needs of minorities are identified and addressed.
10. Encourage and support community-based and community-generated research efforts. This perspective is vital to understanding the health needs of the minority community, as state, university, or Federal researchers do not often accurately assess or understand the situation of specific communities.
11. Promote the development and use of positive HIV/AIDS public service announcements and educational materials related to living with HIV and AIDS, e.g., proper nutrition, family and social support. Positive messages can also be communicated in the form of a newsletter directed to staff and clients of community-based organizations.
12. Federal agencies' grant review panels must take into consideration rural/urban differences in operational and logistical costs, as well as staffing requirements, when selecting CBO HIV/AIDS education/prevention projects for funding. Consideration must be given to extraordinary travel, logistical, and support services costs when reviewing rural CBO grant proposals. For example, the cost of outreach to rural areas that can only be reached by airplane in Alaska, could be considerably more than outreach in an urban area. Consequently, the travel budget for a rural project could give the appearance of being excessive when compared to one for an urban project. Both deserve equal consideration based on technical merit and other key criteria.

IV. Analysis

A. Strategy

This study defined four variables as outcomes: (1) attainment of project objectives, (2) the degree of influence of the project on local health care providers/system, (3) the number of project functions that continued after OMH funding ended, and (4) the number of unanticipated community benefits. After a preliminary analysis, it was hypothesized that these outcomes depended on nine influencing factors:

1. Existence of AIDS-related activities before the OMH grant;
2. Project organization linkage to health care-related provider(s) or project linkage to social service agencies;
3. Project programmatic complexity (e.g., education, outreach, referrals, screening, case management, health/medical care, transportation, and translating educational materials and messages for target population);
4. Project population focus (e.g., focusing on a particular behavioral subset of the population, or the total community);
5. Project design that fit the population/community;
6. Community input during formative and implementation stages;
7. Project implementation: flexibility/adaptiveness to contingencies;
8. Project implementation: expansion of services;
9. Role of OMH, including functions, monitoring and oversight, available monies, quality of relationship, technical assistance offered.

The study's four outcomes were generally measured at the ordinal level with five categories (e.g., none, few, some, most, all). Factors that influenced those outcomes were either measured as naturally occurring dichotomies (e.g., yes, no) or ordinals with three categories (e.g., minimal, moderate, high).

Because study variables tended to consist of ordinal measures, the **Mann-Whitney-Wilcoxon Rank Sum** test was used for statistical testing of relationships. Gamma was used to measure the strength or magnitude of statistical associations. These statistics were selected for several reasons. First, parametric statistical tests like chi square and Pearsons' R are appropriate for interval level data⁷, but inappropriate for use with ordinal level data⁸. Second, small sample size, such as the one in this study (**N=9**), reduces the sensitivity of many parametric measures. Furthermore, small sample sizes often do not meet the assumptions of normality in distributions for parametric

⁷ Data with an arbitrarily chosen zero point that classifies variables by rank ordering them on an equally-spaced continuum.

⁸ Data that measure high to low.

statistics.⁹ The Mann-Whitney-Wilcoxon Sum Rank was used to test for statistically significant associations of factors that influenced outcomes with three categories. The student's T-test was used to test for statistically-significant associations between the overall score on the critical outcome factors (an interval level measure) and the "independent" variables. Gamma was then used to measure the strength or intensity of the effects of the study's ordinal measures on the four outcome variables.

While there are many noteworthy events and persons represented by all of the sponsored projects, this analysis limits itself to a close examination of only four outcomes: (1) the attainment of project objectives; (2) the perceived degree of influence of the project on local health care providers/system; (3) the number of project functions that continued after OMH funding ended; and (4) the number of unanticipated community benefits.

There are several reasons for the importance of these factors. The life of a project begins with the conceptualization of its goals and objectives during the proposal submission process. The award of OMH funding reaffirms this rational, purposively created life and establishes the grantee and OMH as primary "caregivers." Program activities during the life of a project generate changes in individuals and communities that may be marked by qualitative and quantitative changes. In a sense, during the life of the project, the attainment of any, some, or all of a project's goals and objectives represents a kind of developmental milestone that marks the growth and change of a project from its abstract form at its conception, to observable, verifiable outcomes at the end of the funding period.

The perceived degree of influence of the project on local health care providers/systems at the end of the funding period is also important because it represents one measure of the power and resourcefulness of the project to influence individuals and institutions that are critical to increasing access to existing resources, and may lead to a wider use of effective interventions developed by the project. In this context, the continuation of a project after the OMH grant period also represents a developmental milestone because the continuation of project functions after funding has ended represents a successful negotiation of the transition from dependence on OMH, the Federal "provider," to independence. Finally, any unanticipated benefits to

⁹ During the preliminary analysis, an examination of the univariate frequency distributions of the study's variables revealed that the distributions of many study variables departed from that of a "normal" distribution. The nonparametric measures used in this study do not impose such restrictions on the distribution of study variables (Seigel, 1952; Champion, 1970; Seigel 1952). The **Kruskal-Wallis** one-way analysis of variance test was used to perform statistical testing of both the dichotomized independent variables and ordinal dependent variables. This procedure "...ranks all cases from groups in a single series, and computes the rank sum for each group. Each category of response for the dichotomized group was treated as independent sample for the computation of the rank sum."(SPSS, 1988).

individuals and communities serve as an expression of the uniqueness and creativity of the project in the context of the community's life.

The discussion that follows describes overall patterns in each of the above four outcomes. In addition, factors that appear to contribute to or associated with these outcomes are discussed, and examples from all nine participating projects are given. Values of statistical tests that support these conclusions appear in footnotes throughout the text.

B. Results

Attainment of Project Objectives

All projects were successful in achieving this outcome. Indeed, seven of the nine projects (78 percent) achieved most of their objectives, and two (22 percent) achieved all of their objectives [See Table 1, below]. Several factors appear to affect the attainment of project objectives. Statistical analysis indicates, however, that none of the study's nine influencing factors had a statistically-significant relationship with attainment of project objectives. A project's (a) population focus (e.g., whether the project targeted behavioral subsets versus the total community), (b) the extent of linkage to health care and other social service providers, and (c) the degree of programmatic complexity, appeared to have greater effects on the attainment of project objectives than did (d) community input during formative and implementation stages, and (e) the extent to which a project was designed to fit population/community characteristics.

If programmatic complexity, project population focus, project design, community input, and several dimensions of project implementation did not appear to be related to the attainment of project objectives, what factors did actually enhance or contribute to this outcome? In explaining the factors that influenced the attainment of project objectives, it is quite possible to consider that characteristics of project staff were critical to this process. The TI Team observed that the commitment and dedication of project staff maximized the efficient use of limited project resources at all nine projects. In general, each one of the projects retained staff who, during the project period and beyond, dedicated excess time, resources, and commitment for the benefit of the project and target population. Combining the above five factors with project staff commitment may serve to explain how projects achieved, and in some cases exceeded, their stated objectives. In other words, perhaps the measurement procedures for project characteristics were too broad to accurately capture project design or complexity in any statistically-meaningful way.

It would be instructive to point out examples of how commitment from project staff, when combined with any of the above factors, may have influenced the attainment of project objectives. For example, in Goleta CA, the project director made himself

<p style="text-align: center;">TABLE 1. OMH HIV/AIDS Education/Prevention Grants 1988-I 989 Individual Project Results for Outcome Factors (N = 9)</p>					
OUTCOMES	None	Few	Some	Most	All
Attainment	0	0	0	7	2
Influence	0	3	3	2	1
Continuation	0	2	3	1	3
Community Benefits+*	0	1	3	2	3

** Measurements of community benefits are more appropriately represented by the categories: none; minimal; moderate; many; great.

available to conduct presentations at worksites for migrants throughout Santa Barbara County. By remaining flexible and devoting his time to conducting the presentations whenever workers' schedules permitted, he was able to reach members of the target population at their convenience and to disseminate information to areas beyond the scope of project goals and objectives. In doing so, he maintained a role as the sole link to educating migrant workers at their place of work in Santa Barbara County.

In Atlanta GA, Outreach, Inc. carried out an AIDS education and outreach program for Black intravenous drug users. The organization itself was client- and employee-driven, support groups and outreach were peer-led, and programmatic decision-making was a consensual process among staff and clients, to best address the needs of those served. In some cases, project objectives were achieved when staff worked overtime (after work hours and weekends) without compensation, and used out-of-pocket funds to implement an activity or assist a client in need. These characteristics were consistent across projects.

Influence on Local Health Care Providers/Systems

Only one factor appears to have a statistically-significant relationship in the degree to which a project is perceived to influence local health care providers and/or systems. Projects that were designed to fit the population/community were more likely to have a relatively high level of influence when compared to other study variables such as population focus, programmatic complexity, and community input [See Table 2, below]. In Minneapolis, MN, the Indian Health Board identified community participation, collaboration, and cooperation as key issues in designing, launching, and establishing their AIDS education program for the Indian community in Minnesota. By using an approach that was inclusive of all community members, non-threatening, and broad in scope, the Indian Health Board (IHB) was receiving, by the end of the project period, requests to hold presentations in a variety of forums, including reservations, schools, adult and juvenile correction facilities, IHB clinics, health fairs, in-state and out-of-state conferences, and youth centers. The wide applicability of IHB's approach continues to make inroads with local, state, and regional health care facilities. In another example, Outreach, Inc. in Atlanta GA has earned the respect and trust of several social service agencies to the degree that these organizations have made office space available for an Outreach staff member to provide educational and counselling services on their premises.

The TI Team observed that when projects established and maintained linkages with other health service facilities, either through project staff or advisory board members, their projects were more likely to be involved in local decision-making processes about HIV/AIDS services. However, there still exist institutional barriers, especially at the state level, to minority people in general, in gaining access to funding and decision-making processes.

TABLE 2.
OMH HIV/AIDS Education/Prevention Grants 1988-I 989
Individual Project Results for Influencing Factors

Influencing Factors	Project Results (N=9)		
1. Prior AIDS-Related Activities	Yes = 6 No = 3		
2. Population Focus	Target Population Only = 4 Total Community Focus = 5		
	Minimal	Moderate	High
3. Project Linkage to Health/Social Services	2	2	5
4. Project Programmatic Complexity	2	3	4
5. Design to Fit Population	0	4	5
6. Community Input	2	3	4
7. Implementation: Flexibility	2	2	5
8. Implementation: Expansion of Services	4	2	3
9. Role of OMH	8	1	0

Continuation of Project Functions

All projects managed to carry out some program functions even after OMH funding ended. In the sample, two projects carried out a few functions, three carried out some functions, one continued many functions, and three performed all the original, plus additional functions beyond OMH funding [See Table I]. The existence of AIDS-related activities before OMH funding, and the degree to which a project was designed to fit the population/community had statistically-significant relationships in the continuation of functions after the end of OMH funding. First, projects that tended to have engaged in AIDS-related activities before the OMH grant (e.g., education, outreach, and materials distribution), were more likely to continue to carry out a relatively greater number of functions than those that did not. For example, in San Antonio TX, the Hispanic AIDS Committee (HAC) was established before the OMH grant to specifically educate the Hispanic community in San Antonio about the threat of AIDS. Focus group sessions were conducted to determine the best strategies to reach the community. HAC is still providing the same services it provided during the OMH grant period, and has even expanded its services to address the growing needs in its community, e.g., a 12-bed facility to accommodate homeless HIV seropositive individuals. Similarly, in Atlanta GA, Outreach, Inc. sought to expand the breadth of its services with the OMH grant, as it was providing outreach, education, testing, and support services, among other activities, before OMH funding. Outreach, Inc. continues to provide all the services offered during OMH funding, and has also expanded their service delivery activities, e.g., courthouse-based HIV/AIDS education for certain offenders.

Secondly, designing the project to fit the community, as in Brooklyn NY, helped very much in continuing project functions despite lack of funds. In Brooklyn, the Haitian Centers Council designed a media campaign using radio and television broadcasts in Creole to reach Haitians in the New York City metropolitan area and vicinity. After OMH funding, the radio and television programs were so popular with the Haitian community that the project director continued to record the radio program at local stations, dependent upon the amount of community service air time available. This is not to say that continuation without funding is the ideal situation; the reality of CBO budget constraints often do not allow such occurrences. The Brooklyn example points out the need for continued, sustained, and long-term funding in communities that are underserved.

Somewhat surprisingly, linkages with the local system of health care providers had very little effect on the continuation of activities post-OMH funding. This may be attributed to the fact that these CBOs were providing services to communities that were underserved, or where there were no AIDS-related services at all. Linkages with the local system of health care providers are desirable in terms of sharing resources and non-duplication of services, but if an organization is providing a service no one else is providing, continuation may not be contingent upon linkages made with the

“local” system - which may not be located in or considered part of the minority community.

Programmatic complexity also had relatively little effect on continuation. That is, a wide variety of services and/or communities served did not necessarily guarantee that project activities would continue. Similarly, community input during the formative and implementation stages, when compared to the effects of AIDS-related activities before the OMH grant, had relatively little effect on continuation. Again, this may be attributed to the grant-getting process. No matter how well-designed or needed a program may be, continued funding and the presence of other resources and support are, ultimately, key factors in determining the future life of the project.

Projects that limited their focus to behavioral subsets of the population at risk, rather than the total community, tended to continue to perform relatively more functions in the post-OMH period. However, these observed effects may be due to chance factors, because there is no statistically-significant relationship between project focus and the extent of continuation. In fact, funding priorities of Federal and state agencies often dictate the focus of projects to be funded. In order to survive beyond the funding of one project, CBOs often have to be flexible and modify their activities to fit Requests for Applications (RFAs).

Generation of Unanticipated Community Benefits

All projects generated “unanticipated” community benefits to individuals and communities that exceeded the objectives stated in their funded OMH proposals. Indeed, most projects (55 percent) were reviewed by the evaluators as having above average results in this category. Of the nine projects, one project experienced a “few” benefits, three projects had “some” benefits, two projects had “many” benefits, and three projects had “great” benefits [Table I]. The two factors that demonstrated a statistically-significant relationship to the generation of unanticipated community benefits included (a) an organization’s prior participation in AIDS-related activities, and (b) the fit of the project’s design to the population/community. Unanticipated outcomes were measured as those events or consequences resulting from the initiation of the OMH grant activities, e.g., the formation of task forces or groups, career options for staff member, or the negotiation of future funding sources. For example, Detroit, MI was the site of a project that met both of the above factors., and was able to realize benefits for the target community beyond the scope of the project. The project was carried out by the Community Health Awareness Group (C-HAG), an organization formed to meet the needs of Detroit’s Black, HIV seropositive individuals. Because project activities solicited the participation of Black gay men in the Detroit area, a core group of individuals came together at C-HAG to form Detroit’s only group to address the issues of Black gay men, called “Men of Color Motivational Group.” Men of Color has since existed, apart from C-HAG, on the efforts of its all-volunteer membership. Likewise, in Helena, MT, Indian people from all areas of Montana were trained by the

Montana United Indian Association's grant funded by OMH to train AIDS educators. During the last year of MUJA's grant, individual trainers from different parts of Montana organized the Montana Minority AIDS Task Force to coordinate statewide efforts to address HIV/AIDS among all racial/ethnic minority groups in Montana. In Honolulu, HI, former trainees in the Kalihi-Palama Immigrant Service Center's HIV/AIDS train-the-trainer program have gone on to administer their own programs at health facilities in Honolulu and on neighboring islands. One person who is now an education coordinator at a community health clinic in Honolulu has added an HIV/AIDS-oriented television program to an on-going, call-in radio program she produces for the Samoan community. Another individual who works at a neighboring island community clinic has initiated the integration of HIV/AIDS education into the health center's substance abuse prevention program.

Summary and General Discussion of Results

In summary, two factors (prior participation in AIDS-related activities, and the extent to which the project was designed to fit the population/community) appear to have a statistically-significant relationship with Outcomes two, three, and four--influence on local health care providers/system; continuation of project functions; and the generation of unanticipated benefits to individuals and communities. The size or magnitude of the effects of these variables on critical project outcomes remained about the same no matter which outcome was examined. Only one study outcome, the attainment of project objectives, appeared to be unrelated to the nine influencing factors examined in this study.

C. Overview of Overall Project Performance

When a summary index was computed in order to measure each project's overall performance, the importance of participation in AIDS-related activities before OMH funding remained. There were statistically-significant differences in the overall performance of projects that had prior AIDS-related experience and those that did not. In Atlantic City NJ, the Blacks Against AIDS project sought to engage and retain the interests of Atlantic County Black youth to determine their knowledge of HIV/AIDS. BAA's focus on youth and AIDS served as a "wake-up call" in its community to youth at-risk. BAA made good faith efforts to implement the youth's suggestions into program planning, design, and implementation, and BAA's storefront office was transformed into a space where youth could gather, not only to receive AIDS information, but to play games, play records, show videos, and perform arts and crafts. Although the project was unable to maintain funding, BAA served as a model program for Black youth in Atlantic County.

Somewhat surprisingly, there were also statistically-significant differences between projects that experienced relatively high degrees of expansion of services versus those which did not, and overall project performance. Given the significant effect of the

existence of AIDS-related activities, focus, and design for each of the principal outcomes taken separately, the statistically-significant relationship between project expansion and overall project performance was unexpected. It is possible to assume that since CBOs are already a voice of the community and are designed to represent community needs regardless of their AIDS-related focus, the relationship between expansion of services and overall performance represents responsiveness to the community, which in turn enhances the effectiveness in its service delivery capacity. Projects with the highest degree of expansion of services: (a) scored high in all aspects of evaluation measurements, (b) designed projects with the community, for the community, and were carried out by members of the community, (c) met all the needs of clients before seeking funding, and despite lack of funding, (d) all carried out AIDS-related activities for people of color before OMH funding, and (e) were led by dynamic community leaders.

Most project staff perceived OMH as having a minimal role. Only one site reported that OMH had a moderate rather than a minimal or considerable role. A systematic analysis of the relationship of the role of OMH with a project's attainment of objectives, influence on local systems, continuation, and unanticipated benefits revealed that there was no statistically significant relationship. The projects relied primarily on local experts and their own resources to address process, implementation, and evaluation issues.

General Observations

Several general observations were made by the TI Team during the data collection phase that relate to the overall picture across the nine project sites.

- A common mechanism for community input occurs through a formal needs assessment process, yet these projects gave little attention to needs assessment before the commencement of project activities. Explanations for not conducting needs assessment could be that: (1) 66 percent (6 of 9) of the projects engaged in some form of HIV/AIDS education/prevention activity before OMH funding and, therefore, a needs assessment was considered unnecessary, or (2) in most cases, project target areas had extremely low levels of HIV/AIDS awareness in their communities to begin with. Most projects indicated that HIV/AIDS is still a highly stigmatized disease among target populations, and characterized by high levels of denial.
- None of the projects visited conducted an impact evaluation to determine the level of behavior change among their target populations. This was not required of them; furthermore, the time frame and resources to conduct this kind of evaluation were not available to them.

- Seven of the nine projects selected for this evaluation are still active. In all cases, HIV/AIDS education/prevention programs have been integrated into on-going services, either at the CBO, or into other public entities. For example, three of the seven still-active projects have initiated educational components in the judicial/penal systems. Regularly-scheduled HIV/AIDS educational sessions are held for clients of the court or inmates in correctional facilities, and one project has even extended this service to a women's shelter. At the CBO level, staff realized as they interacted with their respective target populations that a more comprehensive approach was necessary to make a difference in the lives of those who are infected or affected by HIV/AIDS. Consequently, all of the seven active projects have plans for, make regular referrals to, or are engaged in the following activities: providing transportation for social services, offering housing assistance, HIV testing and counseling, case management, conducting support groups, and handling foster care and burial needs. They found out that education alone is not enough, and that gaps in the provision of related social services would have to be addressed by the CBO where possible.
- Most projects indicated the need, or were in the process of dealing with, staff support to process job-related and personal grief and stress resulting from intense and sustained involvement with people affected or infected with HIV. High burnout rates were associated with being a staff member of a project dealing with HIV and AIDS.
- Negative effects were few but noteworthy. Staff members from at least two projects were singled out and ostracized by either family or community members for conducting HIV/AIDS-related outreach and education. In both cases, staff members resisted this kind of pressure and continued with their activities. Five of the nine projects experienced some form of "turf battle" with other organizations while involved in conducting HIV/AIDS education and/or service delivery. None of the projects have received (in the past or currently) the funding from local, state, and Federal resources that they need to deal with the prevalence of HIV/AIDS among their target population. For example, one project that had its Federal funds channeled through the state had its funds substantially cut in the last fiscal year. Mechanisms for getting available Federal and state funding for HIV/AIDS education and prevention programs must be strengthened in order to ensure that they reach all target populations in need.
- Seven of the nine projects that targeted adults or the general population have recognized the need to develop special programs for youth. Two of those seven have since initiated programs for youth. The evaluation team made visits to two school-based and one community-based youth programs that appeared to have the support of parents and the school administration. Each reported success in reaching their target audiences, though one teacher felt that the youth program

would be even more effective if a young person with AIDS was available to speak to other youth about the importance of prevention.

V. Conclusions and Recommendations

A. Conclusions

The conclusions that follow are based on the multiple case study analysis and general observations made by the TI Team during site visits.

1. The projects under review achieved all (two projects) or most (seven projects) of their objectives.
2. OMH direct funding made it possible for essential HIV/AIDS education and prevention services to be provided in racial/ethnic minority communities. However, OMH did not have sufficient funding, personnel, or in-place systems during the period under review to monitor projects and provide most of the technical assistance that would have been useful to these demonstration projects.
3. A common characteristic of all nine projects was an intense and sincere commitment of project staff to achieving project goals, and a willingness to contribute extra time and personal resources to meet the needs of the target populations.
4. CBO HIV/AIDS education/prevention projects that have a specific population focus, strong linkages to social services, and offer a broad range of related HIV/AIDS services — either directly or indirectly — are more likely to achieve most of their program objectives.
5. Projects that consistently demonstrate effectiveness in reaching their target communities are more likely to influence health care providers and other social service agencies.
6. Projects that are engaged in HIV/AIDS programs before OMH funding are more likely to continue HIV/AIDS program activities after OMH funding has ended.
7. More program development and resources are needed to address the complexity of issues related to HIV/AIDS and **STDs** and their effects among youth, and the impact of alcohol and other drugs and how they put individuals and families at risk for HIV/AIDS and other **STDs**.
8. Racial/ethnic minority CBOs are not receiving available HIV/AIDS funding and support from local, state and Federal sources in proportion to the prevalence of the disease in their communities.

B. Recommendations

The recommendations that follow are based on the study's conclusions as well as the collective viewpoints of the evaluation team and grantees. The use of a strong imperative in stating most of the recommendations is not meant to be provocative. It honors a commitment to the grantees to reflect their contributions and suggestions at the post-evaluation grantees/advisory committee conference.

Recommendations for Projects

1. **CBOs** must determine where HIV/AIDS education/prevention gaps exist in their communities. To the degree possible, **CBOs** should form viable linkages with community-based health provider entities and social service agencies in order to provide coordinated and comprehensive HIV/AIDS health services in the community.
2. Projects should incorporate AIDS-related activities that existed before Federal funding into the conceptualization and implementation of the project. Projects that build upon existing AIDS activities may be better able to influence the local health care and social service agencies, and are more likely to continue after Federal funding ends.
3. Projects must conduct and document internal formative/process evaluation. This will lead to the early identification and resolution of educational barriers and constraints, strengthening of the project's responsiveness to changing needs, and provide a data base to demonstrate effectiveness and attract resources to sustain the project.
4. **CBOs** should actively seek required technical assistance from all available sources as the need arises. Appropriate and timely technical assistance contributes to staff capacity building and project effectiveness.
5. Racial/ethnic minority **CBOs** must take the initiative to ensure meaningful representation in the current Centers for Disease Control and Prevention (CDC)-sponsored HIV Prevention Community Planning Process (PCPP), e.g., organize local racial/ethnic minority CBO HIV/AIDS Councils to elect representatives for the PCPP; identify representatives of the councils to serve on subcommittees or regional committees organized by PCPP; communicate frequently with elected officials; and make suggestions to the CDC program officer assigned to their respective region/city/project.

6. CBOs should fully utilize the OMH Resource Center services that can assist in carrying out project objectives. In turn, CBOs should provide the OMH Resource Center with information and materials of potential interest and utility to other projects and Federal agencies. The OMH Resource Center's toll-free number is: 1-800-444-6472.

Recommendations for Federal Funding Agencies

1. Federal funding agencies seeking to have local impact in HIV/AIDS risk-reduction/prevention must give priority to funding community-based organizations that have demonstrated effectiveness in meeting community needs.
2. The awarding of grants to health provider organizations to carry out HIV/AIDS risk-reduction/prevention efforts should be made contingent upon demonstrated evidence of the active role of CBOs as representatives of their communities in all programmatic decision-making processes.
3. In light of the demonstrated effectiveness of directly-funded programs, Federal funding agencies must continue their commitment to providing grants directly to deserving CBOs, in addition to addressing local needs through community-based partnership.
4. Funding guidelines must specify the requirements for conducting and documenting internal formative/process evaluation in all such projects. This would provide Federal agencies with the information they require to better target limited funds in the future.
5. The Request for Proposal (RFP) should also specify that by accepting a Federal grant, recipients agree to participate in Federal agency-sponsored external evaluations.
6. In order to establish a continuity of relationship to grantees, Federal agencies must monitor projects through site visits, response to periodic reports, and maintain on-going communication throughout the project period. Consideration should be given to using the Centers for Disease Control Cooperative Agreement model.
7. Federal agencies must assist with defining, providing, and referring CBOs to sources of technical assistance (TA) as needed throughout the grant period. This can be done through site visits, regular grantees meetings, written and telephone communication.

8. OMH must continue to assist racial/ethnic minority communities in the following ways: (a) provide information about Federal funding opportunities; (b) continue its role as advocate for racial/ethnic minority populations within the Federal government; and (c) broaden the OMH Resource Center functions to include solicitation of effective educational and training materials developed by grantees, and the reproduction and distribution of these materials (including bilingual editions) on a regular basis.
9. Projects must be made aware of the benefits of evaluation. Federal funding agencies must set aside monies for and inform grantees of available technical assistance for evaluation in the RFP.
10. The OMH Resource Center must organize a data base of examples of specific materials commonly used (e.g., needs assessment instruments, evaluation tools, confidentiality statements) by OMH grantees (past and present) and other racial/ethnic minority CBO's.

Recommendations for Future Research

1. Assess the strength of the relationship/association of project planning, implementation and outcomes with the nine influencing factors in a larger sample of CBO HIV/AIDS education/prevention projects.
2. Identify key influencing factors that determine the similarities and differences of racial/ethnic CBO HIV/AIDS education/prevention projects in rural areas. Determine if they are different from those that are associated with effective urban CBO HIV/AIDS projects.
3. Examine the competitive grant process and its impact upon collaboration among organizations in the same geographical area.
4. Examine agency management practices at the Federal level and how they affect relationships with CBO grantees.

APPENDIX A

ADVISORY COMMITTEE

for the

OMH MINORITY HIV/AIDS EDUCATION/PREVENTION GRANT EVALUATION
(1988-1989)

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APPENDIX B

OMH Minority HIV/AIDS Education Prevention Grant Program
Evaluation / Multiple Case Study Analysis (1988-1989)

TI SITE VISIT TEAM: Clarence Hall and Kathleen Quirk

PROJECT CONTACTS and FIELD RESEARCH GUIDES:

1. Location: **Goleta, CA: Programa de Educacion Sobre el SIDA/AIDS**
Contact: Rita Madden, Community Action Commission
Field Guide: Francisco Reynoso
2. Location: **Atlanta, GA: OUTREACH, Inc. Minority AIDS Education Project**
Contact: Sandra McDonald, OUTREACH, Inc.
Field Guide: Sedrick Gardener
3. Location: **Honolulu, HI: HIV Education Workshops for Immigrant and Refugee Service Providers**
Contact: Patricia Brandt, The Immigrant Service Center
Field Guide: Richard Chabot
4. Location: **Detroit, MI: Education for Black HIV Positives in Metro Detroit**
Contact: Dorothy Campbell, Community Health Awareness Group
Field Guides: Cornelius Wilson, James Boyce
5. Location: **Minneapolis, MN: Indian AIDS Prevention Risk Reduction Project**
Contact: Rene' Whiterabbit, Minneapolis Indian Health Board, Inc.
Field Guide: Richard LaFortune
6. Location: **Helena, MT: The AIDS/HIV Education and Deterrence Program**
Contact: Bernadine Wallace, Montana United Indian Association
Field Guide: Toni Plummer
7. Location: **Atlantic City, NJ: HIV Risk Reduction Among Atlantic County Black Youth**
Contact: Ava Brown, Volunteer, Blacks Against AIDS
Field Guide: Keisha Terry
8. Location: **Brooklyn, NY: Haitian Coalition on AIDS**
Contact: Marie Pierre-Louis, Haitian Centers Council
Field Guide: Yvon Rosemon
9. Location: **San Antonio, TX: South Texas AIDS Education for Mexican Americans**
Contact: Jose Hernandez, Hispanic AIDS Committee
Field Guides: Irma Aquilar, Edward Porter

APPENDIX C

PROJECT PROFILE

Project Title:

Location:

Year of Grant Award:

Amount of Grant Award:

Grant Number:

Grantee Organization:

Type of Organization:

Project Director:
(Principal Investigator)

Current Key Contact:

Project Documentation Reviewed:

DOCUMENTATION

___ Application
___ Summary Statement
___ Continuation Funding Application(s)
___ Final Report

___ Evaluation Report
___ Evaluation Plan
___ Financial Information
___ Products and/or Educational Materials

Year End Reports:

___ 1 ___ 2 ___ 3

Miscellaneous Information
(Please Specify):

I. THE MINORITY COMMUNITY(IES)' HEALTH PROBLEM(S)

A. The Social Context

1. The Setting: Overview (The Larger Community)

- a. location
- b. sociocultural characteristics
- c. sociodemographic characteristics
- d. socioeconomic characteristics
- e. health care resources

2. The Minority Community(ies)

- a. sociocultural characteristics
 - 1) social organization
 - a) community organization and institutions
 - b) family organization and dynamics
 - 2) language(s)
 - 3) religion(s)
 - 4) health-seeking behaviors
 - a) traditional
 - b) current
- b. sociodemographic characteristics
 - 1) number
 - 2) distribution
- c. socioeconomic characteristics
 - 1) employment
 - 2) income
 - 3) female head of household
 - 4) public assistance
 - 5) level of education
- d. relations with larger (majority) community
- e. accessible health care resources

B. The Minority Community's(ies)' and the HIV/AIDS Health Problem

1. Health Status

- a. life expectancy (including infant mortality)
- b. fertility rate (including adolescent pregnancy)
- c. incidence (or estimation) of HIV infection and/or related health problems
- d. prevalence (or estimation) of HIV infection and/or related health problems

2. Contributing Health Risk Factors

II. THE RESPONSE

A. The Community-Based Organization

1. Formation (who, when, where, why, how)
2. Membership (Organizational/Individual)
3. Mission of CBO
4. Genesis of the Project
 - a. target population(s) (**ethnicity/age/sex/catchment area**)
 - b. identified health risk factors

B. Initiation of the Project

1. Plan of Project Roles and Functions
(community participation in project planning and implementation, needs assessment, collaborative facilitation of intervention activities, contribution of in-kind staff support and other resources, etc.)
2. Design of Project Organizational Approach
 - a. personnel and functions
 - 1) paid staff
 - 2) volunteers
 - 3) others (consultants, interns, etc.)
 - b. base of operations
 - c. other service delivery/health promotion sites
 - d. cooperation with coalition/non-coalition agencies
3. Delineation of Project Goal(s) and Objectives
4. Design of Specific Health Risk Reduction Interventions to Meet Project Objectives
(screening, training, counseling, health promotion information dissemination techniques and materials, etc.)
5. Plan to Ensure Cultural Appropriateness of Project Approach and Interventions
(selection of personnel, target population research, target population(s) consultation in formulation of intervention strategies, testing of health promotion/risk reduction techniques and materials, evaluation design, etc.)

6. Design of Project Evaluation
(focus, methods, internal/external evaluation, target population(s) consultation, collection of baseline target population(s) data, process evaluation, outcome evaluation, etc.)

III. PROJECT IMPLEMENTATION

A. Roles and Functions

1. Description of Implementation and Process
2. Comparison to Original Plan: Same/Changes
3. Changes
(in staff, roles, functions, relationships, participation: due to unforeseen circumstances, differing levels of interest, **interpersonal/interorganizational** dynamics, etc.)

B. Project Organizational Approach

1. Description of Implementation and Process
2. Comparison to Original Design: Same/Changes
3. Changes
(in personnel, functions, sites: due to unforeseen developments, addition/lack of resources, cultural inappropriateness, evaluation/informal feedback, etc.)

C. Project Interventions

1. Description of Implementation and Process
2. Comparison to Original Design: Same/Changes
3. Changes
(additions, deletions, modifications: due to unforeseen developments, addition/lack of resources, cultural inappropriateness, evaluation/informal feedback, etc.)

D. Cultural Appropriateness of Approach and Interventions

1. Description of Implementation and Process

2. Comparison to Original Design: Same/Changes

3. Changes

(in approach, interventions: due to unforeseen circumstances, evaluation/informal feedback, etc.)

E. Project Evaluation

1. Description of Implementation and Process

2. Comparison to Original Design: Same/Changes

3. Changes

(additions, deletions, modifications: due to unforeseen circumstances, addition/lack of resources, cultural inappropriateness, evaluation/informal feedback, etc.)

IV. PROJECT OUTCOMES

A. Roles and Functions, Organizational Approach

1. Relative Effectiveness in Terms of Original Plan

(accomplishments, shortcomings, empowerment of minority community(ies), unanticipated outcomes for minority community(ies), minority community interest in project continuation, efforts to secure resources for continuation/results, etc.)

2. Project Status at Conclusion of OMH Grant Period

(resources, personnel, functions, service sites, etc.)

3. Description of Project Status and/or CBO HIV/AIDS Intervention in 1994

(resources, personnel, functions, service sites, etc.)

B. Project Interventions

1. Relative Effectiveness in Terms of Original Intervention Design, Project Objectives, and Project Goal(s)

(accomplishments, shortcomings, unanticipated outcomes for beneficiaries/providers, etc.)

2. Status of Interventions at Conclusion of OMH Grant Period

(resources; additions, deletions, modifications, etc.)

3. Description of Interventions in 1994

(resources, additions, deletions, modifications, etc.)

C. Project Cultural Appropriateness

1. Effectiveness in Terms of Original Plan to Ensure Cultural Appropriateness

(accomplishments, shortcomings, unanticipated outcomes for target population(s)/project; minority community interest in project continuation, etc.)

2. Cultural Appropriateness of Project at Conclusion of OMH Grant Period

(project approach and interventions, etc.)

3. Cultural Appropriateness of Project in 1994

(project approach and interventions, etc.)

D. Project Evaluation

1. Effectiveness in Terms of Original Design

(accomplishments, shortcomings, unanticipated outcomes for target population(s)/project, etc.)

2. Status of Evaluation at Conclusion of OMH Grant Period

(resources; results of process evaluation, outcome evaluation, etc.)

3. Status of Evaluation in 1994

(resources; further analysis/results of earlier research, continuation of ongoing evaluation initiation of new research, etc.)

V. PROJECT GENERATED LESSONS LEARNED AND RECOMMENDATIONS

A. Lessons Learned

1. Project Approach and Interventions

(regarding feasibility of project goal(s), objectives, and original intervention design, allocation of grant funds and in-kind contribution; interorganizational and cultural appropriateness considerations in staff/volunteer and service site selection and division of labor/functions; number/combination of interventions geared to number/combination of target populations, etc.; how might have been more effective if done differently)

2. Project Cultural Appropriateness

(project approach and interventions; evaluation design and methods, etc.; how might have been more effective if done differently)

3. Project Evaluation

(regarding allocation of time/effort and grant resources/in-kind contributions; focus and methods; cultural appropriateness, etc.; how might have been more effective if done differently)

4. Other

5. OMH Minority HIV/AIDS Education/Prevention Demonstration Grant Program

(regarding focus and health problem priorities; amount of award, timeframe; grant application guidelines and process; grant administration and reporting requirements; feedback and technical assistance, etc.; how might have been more effective if done differently)

B. Recommendations

1. Project: Initiation, Resource Generation/Allocation, Implementation, and Outcomes

2. Project Cultural Appropriateness

3. Project Evaluation

4. OMH Minority HIV/AIDS Education/Prevention Grant Program

5. Other

APPENDIX D

INTERVIEW INSTRUMENT : CBO PROJECT STAFF MANAGEMENT

Project Title:

Date:

Location:

Interviewer(s): Clarence Hall and Kathleen Quirk

Time Began: _____

Time Completed: _____

Instructions for interviewer(s) are within brackets ([]).

A. PROJECT GOALS AND OBJECTIVES

Extent to which project implementation was consistent with original goals and objectives.

1. What were the **major** objectives of the OMH-funded component of the project?

2. What were the specific services offered to beneficiaries? (e.g., outreach, group education sessions, workshops, provision of educational materials)

3. In retrospect, were the project goals and objectives realistic?

4. How would you rate the degree of accomplishment of objectives of the OMH-funded project? (1=low and 10=high)

___ highly accomplished _ moderately accomplished
___ marginally accomplished _ unaccomplished

5. What, if any, changes (additions, deletions, relative emphasis) were made to project goals or objectives during the three-year period?

6. Why were these changes made?

B. PROJECT STAFF FUNCTIONS AND PROCESS

1. Please explain the roles and functions of the projects key staff.
[DEVELOP STAFF ORGANIZATIONAL CHART]

2. Was there an unusual level (more than once or twice) of staff turnover during the three-year funding period?
- Y e s _____No
 - 2.1 If yes, please explain the nature of the change.
 - 2.2 Did the change strengthen or weaken the project? Please explain.

3. What were the racial/ethnic and gender composition of the staff? How closely did it match the target population?

4. Did the racial/ethnic or gender composition of project staff affect overall accomplishment of project objectives in reaching the target minority population(s)? Please explain.

5. Did the project use community volunteers and/or paid community health workers?
Y e s _ N o _

6. What were their roles?

7. How were they recruited?

8. What incentives were used to sustain the involvement of volunteers, outreach workers and/or peer **educators**?

9. What incentives (if any) were given to project staff to stimulate and maintain their interest and involvement in HIV/AIDS education?

10. What type of HIV/AIDS training was given to project staff, outreach workers and volunteers to ensure quality service.

11. Briefly describe the training to any of the above categories of personnel including type of training, content, duration, venue, and trainers.

12. What were the most disruptive personnel problems among paid staff and volunteers?

13. How were these problems solved?

C. TARGETED MINORITY POPULATIONS AND HEALTH RISKS

The extent to which the projects addressed targeted minority populations and health risks.

Target Population(s)

1. What target groups and subgroups did the project initially plan to reach?
2. What percentage of the intended target population(s) was actually reached? Please explain.
 - 2.1 What data are there to indicate that the project reached all or part of the intended target population(s)?
3. Did the target population(s) change during the funding period? If so, please explain.
4. In retrospect, would it have been best for the project to target a single racial/ethnic minority population _ or multiple racial/ethnic minority populations_ Please explain.

Geographic Target Area(s)

5. What geographic area(s) did the project originally plan to target?
6. During the funding period, did the geographic target area(s) change? If so, please explain.

Targeted Health Risk Behavior(s)

7. What health risk behavior(s) did the project originally plan to address?
8. During the funding period, did you discover changes in the health risk behavior(s) of the target population? If so, please explain.

If yes, did you address these risk behavior changes in your intervention approach?

9. What specific alternative behaviors were advocated as part of education/prevention activities?

D. INTERVENTION METHODS

Intervention methods used by projects to reduce health risks in minority populations.

Needs Assessment / Community Input

1. Did you conduct a needs assessment? Did the target population have input on this needs assessment?

Specific Intervention Objectives

2. What specific intervention activities or services were originally planned (e.g. group education sessions, **counselling/support** services, production of educational materials)?
3. Who delivered the services, how often, and in what setting?
4. What other **CBOs**, public or private organization cooperated with the project to accomplish objectives?
5. What percentage of these activities or services were completed during the project period?
6. How were clients selected or engaged to receive project services?
7. Were the major obstacles encountered in delivering services (e.g., attrition from project)?
 - 7.1 If so, what was done to overcome them?
8. What were the critical events which occurred during the course of implementing the intervention that **contributed** to accomplishing project objectives (e.g., staff training, support by major, corporate donation)?
9. Do you believe that the intervention activities carried out were consistent with the project's stated goals and objectives? Please explain.

10. Did you produce a comprehensive plan for developing and disseminating health information to the beneficiaries? Yes **No.**
11. Did your project/program have a community outreach component?
12. If yes, did you pay outreach workers? Use volunteers? What, if any, percentage of outreach workers were (self-identified) HIV+?
13. What specific tasks did they perform?
14. Were obstacles were encountered?
- 14.1. If so, how were they overcome?

Cultural Appropriateness of Intervention(s) for Target Population(s)

15. What special procedures or approaches were used (or what did you do differently) to make the intervention(s) appropriate for the target minority population(s)? Please explain.
- 15.1 If nothing special or **different**, explain why it was not considered necessary or feasible.
16. Was culture-specific orientation or training provided to the project staff and volunteers? Please explain.
17. What percentage of the project staff/volunteers/outreach workers shared the culture and spoke the language of the target population?
- 1 0 0 % 75% 50% 2 5 % Less than 25%
18. Did the project develop or adopt educational or training materials specifically designed for project staff and/or the target minority population(s)?
- Y e s _ N o _
- 18.1 If yes, specify and provide examples of these materials.
- 18.2 If not, state rationale for not doing so.

19. Were educational/training materials pretested for cultural appropriateness with the target population(s) prior to their use?

Yes _ No _

If no, why not?

19.1 If yes, what method(s) were used?

20. In retrospect, do you feel any of the above materials or interventions should be modified as a result of project experience and feedback from participants?

Yes _ No _

If yes, what modifications?

21. How would you rate the appropriateness of the intervention(s) for the target minority population(s). Would you characterize the intervention(s) as:

highly effective moderately effective

marginally effective ineffective

21.1 What is the basis for this rating?

22. What (if any) specific intervention activities were found to be culturally inappropriate for the target population(s)?

23. What activities were sustained/modified/expanded/discontinued beyond the OMH grant period?

If sustained/modified/expanded, who is responsible for carrying out these activities?

E. PROJECT EVALUATION

The extent to which project evaluation, as implemented by the grantees, facilitated implementation of OMH policy, the continuation/expansion of the Minority HIV/AIDS Education/Prevention Grant, and project implementation.

1. Did the project fund or implement a baseline study of some sort? Please explain.

2. Did the project carry out a formative, process, or outcome evaluation? Please explain.

3. What problems in evaluation, if any, were encountered?
4. Were the data used for evaluation collected as part of, or separate from, the intervention activities? Please explain.
5. What proportion (%) of grant resources were devoted to project evaluation?
6. What were the major findings of the evaluation?
7. What impact did the project have on the target population(s)? What documentation do you have to support statements of impact?

Uses of Data

8. Were evaluation data and analysis regularly fed back to project administration?
9. Did any project changes occur as a result of information feedback provided by the evaluation process? If yes, what changes?
10. How much confidence would you say can be placed in the evaluation data? Please explain.

F. PROJECT REPLICABILITY AND GENERALIZABILITY

The extent to which the programs implemented by the demonstration projects could be duplicated in similar communities.

Replicability in Other Communities

1. Would you rate the projects **replicability** for other communities as highly replicable, moderately replicable, marginally replicable, or not at all replicable?

highly replicable moderately replicable

marginally replicable not replicable

1.1 What is the basis for this rating?

2. What components-if any--of the project could not be replicated, or not easily replicated? Please explain.

1.7 If yes, please explain.

1.8 Please make any additional comments you wish with regard to the OMH Minority HIV/AIDS Education/Prevention Grant Program.

2. Did OMH/NO make a site visit during the three year project period?

3. If so, did you consider the OMH/N.O. staff site visits to comprise technical assistance __, monitoring of your progress __, or both __? Please explain.

4. Did the project seek technical assistance from OMH staff?

4.1 If yes, what kind(s)?

4.2 If not, why not?

5. Was technical assistance provided by OMH/ Washington or your national organization?

Y e s _ N o _

6. If so, how would you describe the overall technical assistance provided by the OMH Washington-based/ NO project officers?

a) very helpful b) helpful c) unhelpful d) insufficient

7. What technical assistance would you like to have that was not provided? Please explain.

8. Please provide suggestions as to how OMH/N.O. technical assistance to grantee projects could be improved.

I. BUDGET

1. What level of funding did you **receive** each year of the project?

2. From what other sources, and at what level of funding did the project receive assistance?

8. What new project activities, if any, have been initiated?

9. Does written documentation exist of the project's activities beyond the grant period?
If so,
 - 9.1 What is the nature of such documentation? (e.g., correspondence, memoranda of agreement, minutes of meetings.)
 - 9.2 Do you have any objection to a review of these documents by the evaluation team during this site visit? Y e s ____ **No.**
 - 9.3 If yes, please explain.

10. If you were to undertake this project again, what would you do differently?

11. What changes should be made to the OMH grant guidelines to enhance the capability of future grantee projects to achieve the purposes of the Minority HIV/AIDS Education/Prevention Grant Program? Please provide suggestions.

12. What do you think is the legacy or main accomplishments of the project?

13. What were the unanticipated outcomes (accomplishments beyond the project objectives and/or previously unidentified needs) of this project?

14. What lessons have you learned about HIV/AIDS education and prevention programs by participating in this OMH grant program?

15. Please make any additional comments or recommendations that you wish.

This report represents the findings of the authors and does not represent an endorsement by the Office of Minority Health, DHHS.