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**Methods for Health Promotion in the Prevention
of HIV Disease in African Americans**

UC Los Angeles
October 14, 1992

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Vickie M. Mays, Ph.D. is an Associate Professor at the University of California, Los Angeles. She is also the Director of the Black Community AIDS Research and Education (Black C.A.R.E.) Project. Her research focuses on the public health policy implications of disease patterns and risk behaviors among women and ethnic minorities. As Director of Black C.A.R.E., Dr. Mays heads a research team and Advisory Board of top AIDS researchers and African American gay men in the first national study of African American men at risk for HIV disease from their sexual activities with other men. In addition, in 1986 she began studying the sexual practices and HIV-related risk behaviors of young, heterosexual Asian Americans, African Americans, Latinos, Whites and Middle Eastern adults in Southern California tracking these behaviors over time. Her research has been supported by the National Institute of Mental Health, the National Institute of Allergy and Infectious Diseases, and the National Center for Health Services Research. Working extensively with the media to disseminate science to the public, she has appeared on Nightline, CNN, Health Quarterly, and was a weekly regular on the California Health Program. She has served on several agency boards, national policy committees and study sections concerned with the health of women and ethnic minorities for groups including the National Institutes of Health, the Public Health Service, the American Public Health Association and the American Psychological Association. In addition, Dr. Mays has held elected offices in local and national professional organizations. She is the editor of **Primary Prevention of AIDS** and has published over 40 articles on the health and mental health of women and ethnic minorities.

Dr. Mays received her Bachelor's and Master's degrees from Loyola University of Chicago and her Ph.D. in Clinical Psychology from the University of Massachusetts, Amherst. She completed postdoctoral studies in survey research with ethnic minorities at the Institute of Social Research, University of Michigan and health policy and health services research at the Rand Corporation and UCLA's School of Public Health.

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Abstract

HIV-related disease, including AIDS, magnifies the economic, social and health problems that so devastate the well-being of the Black community. As the National Commission on AIDS¹ aptly points out, "The HIV epidemic did not leave 37 million without ways to finance medical care but it did dramatize their plight...It did not cause the problems of homelessness -- but expanded it...and made it more visible...It did not cause the collapse of the health care system...but accelerated the disintegration of our public hospitals and intensified their financing problems." The nature of the problem of HIV transmission in the African American community necessitates the development of interventions on a community-wide scale. This means creating models of health promotion that incorporate ethnic-, cultural-, and gender-relevant methods so as to impact cultural norms related to health behaviors and habits and tolerance of ill health. The goal must be one of pushing the health care system away from models oriented both toward individuals and illness toward models that target communities and prevention. Such models offer the hope that wellness can be enjoyed equitably for all members of society.

Introduction

*"The HIV epidemic in African Americans is something that we must all care about regardless of our ethnic/racial background, our sexual orientation, our drug use status, our age, or our moral beliefs. Because the problem of AIDS and HIV disease in Black Americans is one that will affect most everyone for many years to come."*²

For many of you here today, thinking about AIDS and HIV disease may bring to mind images of White gay men on Castro Street in San Francisco, an unfortunate young White woman in Florida infected by her dentist, a Black infant orphaned by AIDS, or recent speakers at the national political conventions. The message shown in media images is clear--we are all at risk for AIDS, young and middle-aged, gay and heterosexual, White and Black alike. But that is not the truth about AIDS. Not all communities are equally impacted by this disease. Black America has already suffered disproportionately from this virus, and the future, if we do nothing to change its course, will be more tragic, perhaps, than the devastation experienced by the gay male community. I say this for many reasons, one of which is that the African American community enters this crisis already lacking resources to tackle existing health problems.

It is with great seriousness that I hope I can convey to you today the reasons you should care about the epidemic's devastating impact on African Americans. This is not just my problem as a Black American, or the problem of the African American community, but it is a problem for all of society. Its solution will also require the attention of everyone in their roles as researchers, volunteers, caretakers, and voting citizens. We must not and should not expect Black America to solve this problem on their own.

While these concerns for the African American community may seem distant to those without direct ties to that community, the truth is that the HIV epidemic in African Americans is something that we must all care about because its impact on the Black community will reverberate, touching the lives of most Americans. Just as AIDS has impacted diverse segments of the African American population, so too will it affect others who, while not personally a part of the Black community, are a part of a society that is influenced by the status African Americans occupy in the labor market, by their health care expenditures, by their illicit drug use, and by their availability or lack thereof as productive citizens.²

AIDS in the African American community has affected and will affect each

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will incur these costs, and how we will divide these costs among the different domains are decisions that may not always be made in the best interests of all of those affected by the AIDS epidemic.

For Black Americans, health policy decisions, even prior to AIDS, have not communicated the level of caring and concern from White Americans for which they might have hoped. Community-wide experiences of discrimination have sown a deep distrust of the intentions of government and individual White Americans. Often we underestimate the impact of real and/or perceived discrimination on African Americans who seek health care or respond to government-issued health warnings. For example, as White America struggles with the issue of whether or not AIDS should be viewed as a disease or a result of immorality, in Black America conspiracy theories flourish. A New York Times/CBS poll in 1990 reported that 29% of the African Americans surveyed believed that the AIDS virus might have been "deliberately created in a laboratory in order to infect Black people."⁶ In a national poll conducted in 1992 by Newsweek (see Table 1), 22% of the 661 Black Americans surveyed blamed the federal government for the problem of AIDS. When the Gallup researchers took a further look at the data, they concluded that this was actually a low estimate. They estimated that approximately 40% of the sample accepted the notion of some type of governmental conspiracy at work in accounting for the problem of AIDS in the African American community.⁷

Table 1. Newsweek Poll of African American Attitudes⁶

Who do you blame most for the following social problems affecting Black Americans?

	Government	African Americans
Drug Abuse	32%	35%
AIDS	22%	24%
High Crime Rates	32%	32%
Broken Families	20%	46%
Teen pregnancy	16%	54%
Poor education	48%	25%
Unemployment	62%	11%
Lack of Black-owned Businesses	37%	28%

(Between 7% and 16% of those polled blame a racist conspiracy for each problem.)

It is hard for many Blacks to believe that the government is really interested in the health of African Americans when their day-to-day experiences range from cuts in benefits to what is perceived as an unjust judicial system. It is a leap of faith that many African Americans who despite their high level of religiosity⁸ do not possess. As a general rule, conspiracy theories and governmental distrust usually follow on the heels of traumatic events such as assassinations⁹ that cause widespread social anxiety. Many residents of inner-city African American communities view the crack and AIDS epidemics as traumatic events in their own community and live day-to-day with threats to their safety.⁶

This distrust translates into the private and public health care arena. When

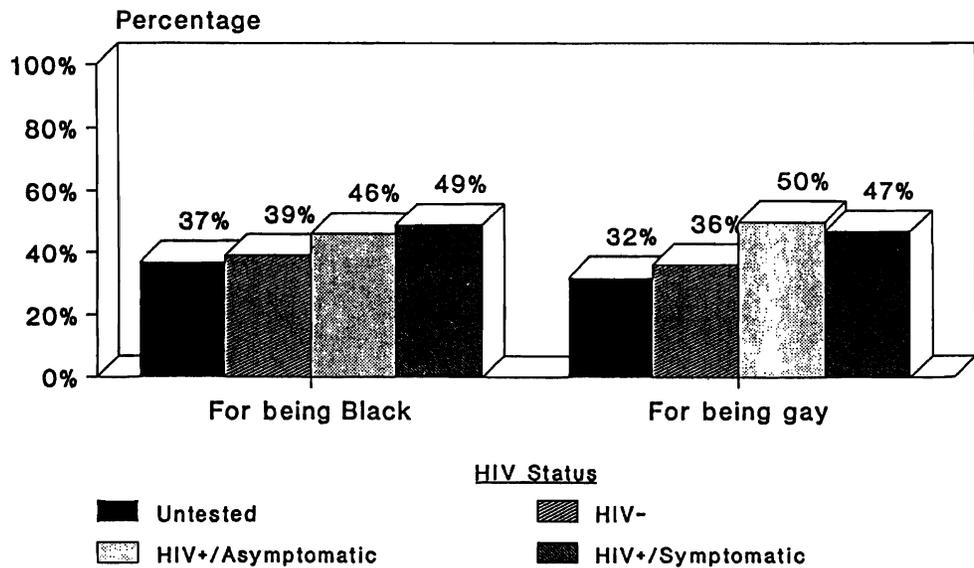
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Figure 2. Experience of Health Care Discrimination by HIV Infection Status¹¹



governmental plot, they may be less inclined to individually change their own behavior. Those who are at high risk may avoid being tested for fear of discrimination. And our educational prevention campaigns may not capture their attention because we fail to address beliefs closely held by them as a function of their ethnic status.

Getting back to the issue of costs associated with AIDS, let me now talk about a different type of costs that concerns many of us. In urban areas such as New York, New Jersey, Washington, D.C. and, as you will see later in this talk, potentially California in the future, AIDS survivors will increasingly include children left without parents to provide and care for them. These children face becoming a part of a foster care system that is already overburdened, underfunded, and not very successful at the placement of older children, particularly those who are African American. Their contributions as productive citizens may be delayed or unfulfilled due to the disruption in their lives as a result of AIDS.

We may never know how great a loss has been suffered here. Cases of AIDS in African American infants and children may rob us of yet another Nobel recipient for peace or a great scientist, inventor, teacher, or even a good friend. Imagine if Magic Johnson, Max Robinson, or Arthur Ashe had never lived to reach adulthood. Imagine, too, the impact of their premature loss to the world. What would have been their future contributions if AIDS had never happened?

One of the great tragedies about AIDS is the persistent belief that those who have been taken from us are not important to the functioning of our society. But this is not so. Let me give you a view from our national survey of HIV in African American men who have sex with men.¹⁵⁻¹⁷ As I said earlier, this survey included responses from 844 men living in 41 states. Of these, 238 reported being HIV-infected or diagnosed with AIDS or ARC. Among this latter group, the median income is \$20-25,000 a year,

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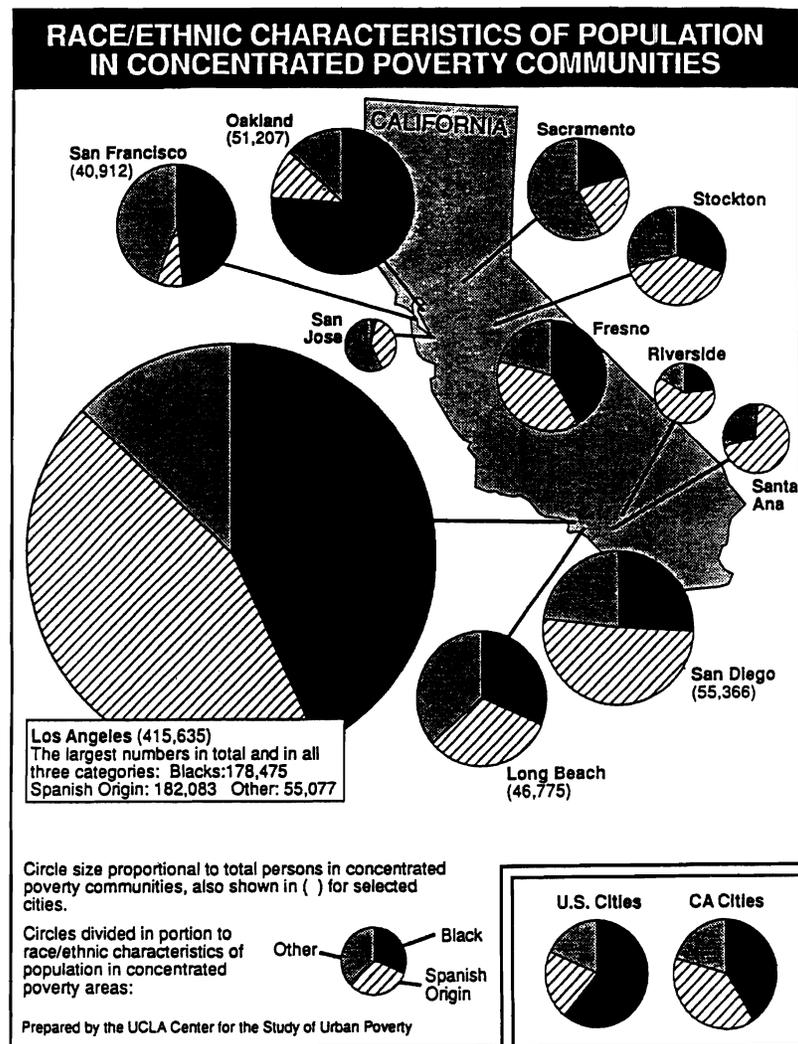
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mismatch between their skills and educational backgrounds and the disappearance from California of jobs in industries where little education is required leaves them with few options.^{26,27}

If we look at two figures graciously supplied by my colleague Dr. Melvin Oliver of the Center for Urban Poverty at UCLA, you can see firsthand the problem of poverty in California. Figure 3 uses data based on the 1980 Census. As you can see, poverty is a major problem for Los Angeles, and for African Americans and Hispanics in Los Angeles in particular. As we are well aware, this economic picture has only worsened since these data were collected. Figure 4 shows the concentration of males in poverty in California. Again, Los Angeles figures prominently in this picture. Please keep these distributions of unemployment in mind when I present the data on the cases of AIDS and HIV infection in California. As you might suspect, the distributions look very similar.

Figure 3. Race/Ethnic Characteristics of Poverty in California²⁶



Part of the goal in presenting this information is to reorient your thinking about HIV from the view of it as merely a health problem in which each individual is solely responsible for prevention. Rather, HIV disease is a health problem, a social problem, and a problem of rights and resources in this country.²⁸ Solutions whose philosophies rely on individualism, on each person for him or herself, will fail and have to date failed

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The Challenge of AIDS in California

What I would like to do at this point is to turn your attention to the challenge of AIDS in California. Looking at the epidemiology of AIDS here in the state might give us some insight into the history of the epidemic and the baggage that we bring to our health promotion efforts with African Americans.

Cases of AIDS in Men

Gay/Bisexual Men. As you can see in Table 2, the greatest number of AIDS cases in African American males are men who have sex with men. This table combines homosexual and bisexual men together, although there is growing data demonstrating that these groups are very different in their social networks, knowledge about HIV, and safer sex practices.³⁴⁻³⁷ Outside of San Francisco, the existence of so many African American men who identify as gay or bisexual has come as a surprise for many in the African American community. Not until the AIDS epidemic has the community been challenged to understand this group and to respond compassionately to their needs.² This unfortunately has proven to be a challenge and a response that many segments of the African American community, as well as the larger society, have failed to achieve.

In order to understand the complex nature of HIV prevention in this population, it might be worthwhile to spend a little time examining issues that affect prevention efforts. First, a difficulty one confronts quite quickly in working with this population has been the lack of visible infrastructures by which African American gay men could be easily and quickly reached. Many of the first HIV efforts at reaching gay men in general were conducted through recruitment and outreach at gay bars and gay bathhouses. However, few of these establishments in California catered to African Americans, particularly those without economic resources. Those bars that had substantial numbers of African American patrons were not targeted for interventions, perhaps because the bars were in ethnic neighborhoods. So while many of our first epidemiologic studies were being conducted, educational interventions carried out, and safer sex norms being established for gay men, many African Americans were not a part of these efforts.

Traditionally in the African American community, primary structures used to reach the general population have included churches, civil rights groups, and community-based grassroots organizations. For many of these groups, the AIDS problem has been a moral one, fueled by ignorance, homophobia, and denial, resulting in the loss of precious time in attempting to stop the spread of the epidemic among homosexually active men.² This ignorance was complicated by the fact that it was not until almost six years into the epidemic that the federal surveillance system began routinely to separate AIDS cases by risk groups, gender, age, and ethnic/racial background, facilitating knowledge of the patterns of the disease in various ethnic groups. Sadly, the State Office of AIDS surveillance reports are still fairly rudimentary in their reporting of data for ethnic minorities by risk group, age, and gender for California.

As researchers, we know very little about the HIV risk-related behaviors, lifestyle, and contextual issues of being both African American and gay or bisexual. This hampers us in offering leadership in prevention efforts, either to the biomedical research community or to the segments of the African American community that have chosen to fight this disease.^{2,38} Sadly, we know less about the behavior of Black men who identify as bisexual than we know about Black gay men. We know even less about the bisexual behavior of those Black men who identify as heterosexual.² Prevention efforts that rely exclusively on models developed from the experiences of White gay men and not on a knowledge base derived from African American men, in all of their various

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complex social groupings, have and will continue to fall short in their effectiveness. This should not surprise us. Any intervention works best with the population it was specifically designed for; any generalization of techniques to additional populations will commonly show a decrement in effectiveness.

African American gay men have shouldered the burden not only of coping with this disease, but of building an infrastructure through which they could mount the kind of large-scale interventions that have successfully worked with White gay men in urban areas of California. But as the California and federal deficits grow, funding for these prevention efforts by gay men of color have begun to erode. It is important that we not lose sight of the necessity of building and maintaining this infrastructure, if we are to successfully conduct health promotion efforts within this population.

Intravenous Drug Users. The second-largest group of men affected by AIDS in the African American community are injection drug users. Unlike African American gay men, the overt presence of drug users in our community has a long history.² Infrastructures exist in the form of state, county, and private drug treatment facilities, and specific funds have been allocated for drug prevention activities. While these infrastructures in the California system have served well as anchors from which to advocate for this population and support risk reduction activities, they too have experienced the heavy hand of public morality, negative attitudes, and ignorance. Such attitudes have slowed the response of African American as well as non-African American communities to this group.²

Somehow in the "us-versus-them" view of drug use in America, we lose sight of the fact that each and every drug user is someone's son, daughter, wife, mother, or parent. As the war on drugs targets enforcement and incarceration, the contextual relationship of the drug trade to the economic health in inner-city African American neighborhoods is lost. Lost too is an awareness of who bears responsibility for the especially deleterious effects on African Americans as the United States economy shifts from one based on manufacturing to one increasingly based on information processing and high technology, while at the same time failing to invest in skill and job training for a large class of displaced people.^{27,39} Governmental policies, such as changes in federal housing subsidy laws, health care entitlement cutbacks, and crises in funding for public education, encourage chronic poverty and antisocial behavior in the form of crime, drug abuse/use, and violence.^{27,39}

It is difficult for many Americans to view injection drug use as a health and social problem that must be solved, that can be solved, if we are to get control over the HIV epidemic.

For the sake of brevity, I won't review each of the other risk groups. Rather, I would like to turn for a moment to that part of Table 2 that reports cases of AIDS in adolescents. As with adults, the greatest number of cases are among young men who have sex with men. We must remember that these young men have not had the benefit of 10 years of HIV education and interventions, as many of them have only in recent years become a part of the gay community. Like heterosexuals in the general population who have not experienced the death of someone close to them from AIDS, it is sometimes difficult for young gay men to embrace fully the risk of HIV disease. A survey conducted by the UCSF AIDS Prevention Center among 18- to 25-year-old gay men found that a significant proportion of men in the study had engaged in anal sex without a condom.⁴⁰ It is important if we do not want to repeat the upper half of the table that we put into place prevention efforts that are age- and experience-appropriate for these young gay men.

Table 3. Total Number of AIDS Cases for Females by Risk Group and Ethnic Background for California through June, 1992*

ADULTS	White	Black	Hispanic	Other	Total
Injection Drug	265 (30%)	315 (51%)	92 (22%)	21 (17%)	693 (34%)
Heterosexual Contact	265 (30%)	162 (26%)	138 (32%)	25 (20%)	590 (29%)
Hemophiliac	8 (<1%)	0 (0%)	0 (0%)	0 (0%)	8 (<1%)
Blood Transfusion	224 (25%)	39 (6%)	71 (17%)	24 (20%)	358 (17%)
No Identified Risk	132 (15%)	105 (17%)	126 (30%)	52 (43%)	415 (20%)
Total Adult Cases	894 (43%)	621 (30%)	427 (21%)	122 (6%)	2,064 (100%)
ADOLESCENTS	White	Black	Hispanic	Other	Total
Injection Drug	1 (14%)	0 (0%)	0 (0%)	2 (100%)	3 (16%)
Heterosexual Contact	3 (43%)	0 (0%)	3 (60%)	0 (0%)	6 (32%)
Hemophiliac	0 (0%)	1 (20%)	1 (20%)	0 (0%)	2 (11%)
Blood Transfusion	1 (14%)	2 (40%)	0 (0%)	0 (0%)	3 (16%)
No Identified Risk	2 (29%)	2 (40%)	1 (20%)	0 (0%)	5 (26%)
Total Adolescent Cases	7 (37%)	5 (26%)	5 (26%)	2 (11%)	19 (100%)

*Data provided by the California State Office of AIDS

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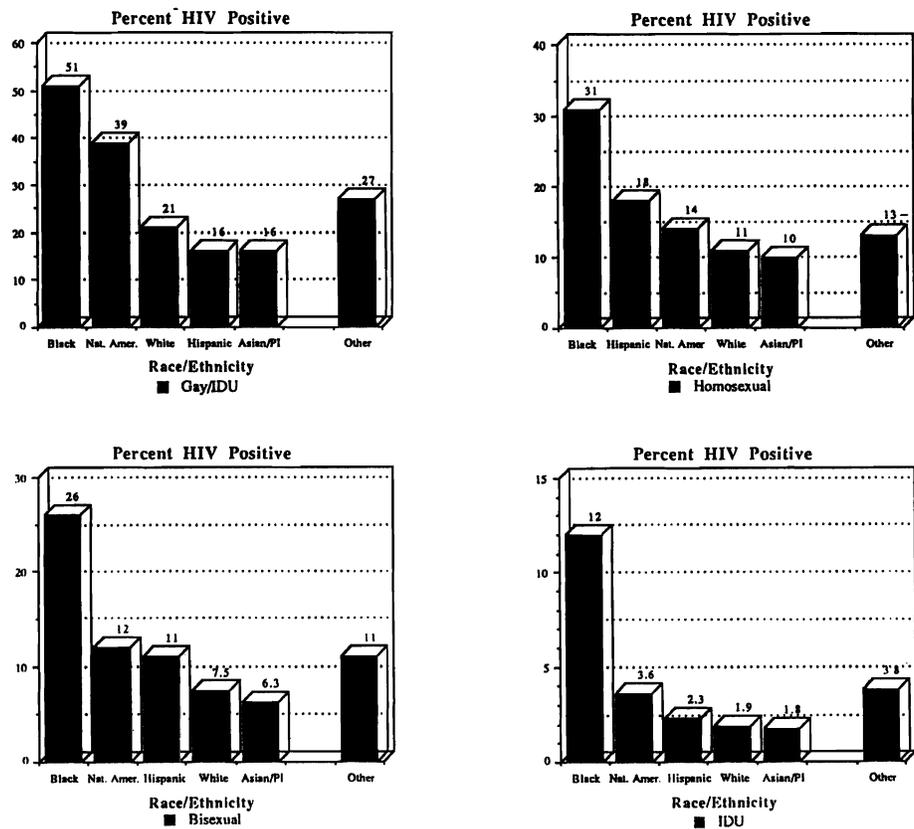
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A View from HIV Test Sites. To broaden our look at seropositivity rates, let me also present some data collected through California's Alternative Test Sites, Public Health Departments, Office of Family Planning Contractors, Department of Alcohol and Drug Programs, and Rural/Community Health programs.⁴⁴ These are test sites throughout California where confidential and anonymous testing is conducted at no charge or for very low fees. In 1990, 320,331 pre-test and 201,284 post-test counseling sessions were provided in these settings. The data presented in Figure 5, while not adequate for the description of population trends, does give a picture of the infection rate.⁴⁴ Again, infection rates among African Americans are significantly higher when compared to all other ethnic/racial groups.⁴⁴ If we were to look at sheer number of cases, White gay men represented 38% of those infected while African Americans

Figure 5. HIV Positivity Rates by Race/Ethnicity in High Risk Groups from California HIV Test Sites 1990.⁴⁴



comprised only 7%. But in rates of infection relative to numbers in the population, Black clients were three times more likely to show antibodies to HIV than White clients.⁴⁴

STD Clinics. We can expect this difference to become increasingly greater in the future. Looking at seroprevalence data in Los Angeles County collected from first-time patients at sexually transmitted disease clinics (see Table 5), Ford and his colleagues³² found an accelerating trend among African Americans. Demographics of the group indicate that a large percentage of the visits were by heterosexual African Americans. As before, this data is not a random sample but rather is skewed to a particular segment of the population. Persons visiting STD clinics are likely to be part of a population with higher risk based on sexual behavior. The occurrence of STDs can sometimes serve as a proxy for high-risk behaviors, such as unprotected intercourse.

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Figure 6. Adjusted Seroprevalence Trends Among STD Patients by Sexual Orientation and Race/Ethnicity Los Angeles County, October 1988 - September 30, 1991³²

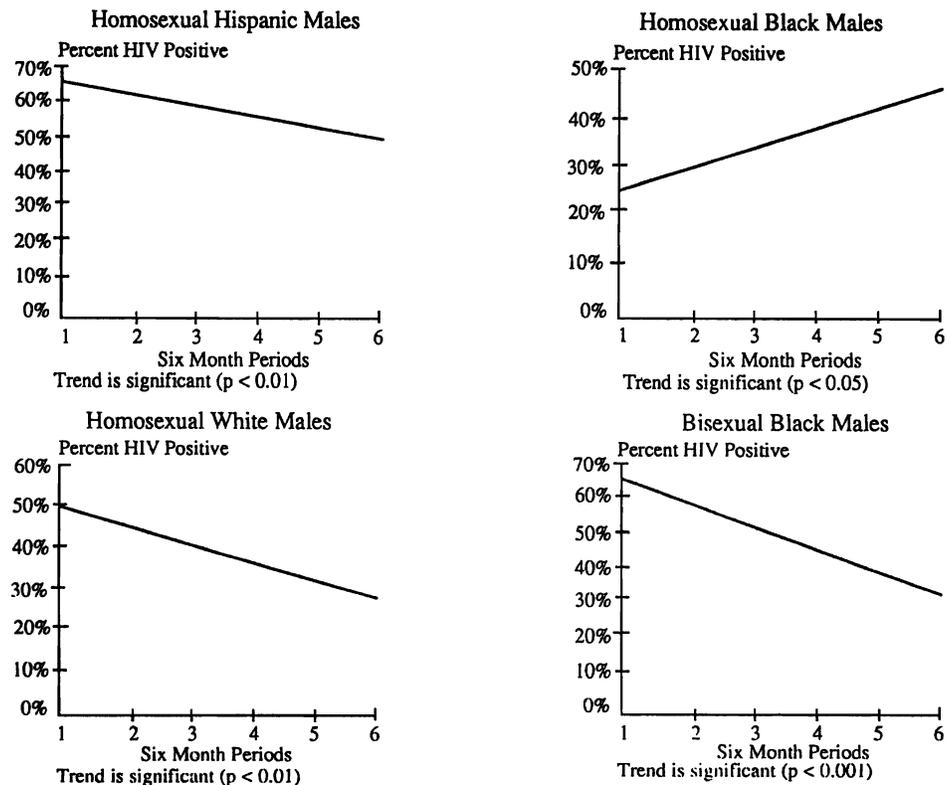


Table 6. HIV Seroprevalence Among Childbearing Women in California by Race/Ethnicity, 1988-1990⁴⁵

Race/ Ethnicity	Total Tested	Number HIV+	Rate/ 10,000	Relative Ratio	95% Confidence Interval	
					Lower	Upper
Asian	26021	5	1.92	0.56	0.22	1.39
Black	31874	123	38.59	11.20	8.21	15.27
Hispanic	164450	88	5.35	1.55	1.12	2.16
White*	171166	59	3.45	1.00	-	-
Other**	37075	24	6.47	1.88	1.17	3.02
Statewide	430586	299	6.94	-	-	-

*This is the reference category for computation of relative ratios; it excludes Hispanic whites. The relative-risk confidence intervals were computed using the Taylor Series developed by Greenland and Robins (Biometrics, 1985, vol. 41, pp. 55-68), as programmed in Epi-Info (Version 5.1).

**Includes unknown. More than one-half of these unknown cases were from the 1988 sample, which had a relatively high rate of missing data. The proportion of cases with missing data declined greatly in both 1989 and 1990. The relative risk for this category would not differ statistically from that for non-Hispanic white women if the data for 1988 were eliminated.

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Table 8. HIV Seroprevalence Among Childbearing Women in California by Age Within Race/Ethnicity Group, 1989-1990⁴⁵

Age by Race/ Ethnicity	Total Tested	Number HIV+	Rate per 10,000
<u>Black</u>			
Under 20	4037	8	19.82
20 - 24	6316	20	31.67
25 - 29	5982	37	61.85
30 - 34	3762	18	47.85
35 and over	1536	4	26.04
Contingency Chi - square = 13.66, df = 4, p < 0.01			
<u>Hispanic</u>			
Under 20	18337	6	3.27
20 - 24	37514	14	3.73
25 - 29	33112	20	6.04
30 - 34	19143	10	5.22
35 and over	9288	5	5.38
Contingency Chi - square = 3.02, df = 4, p < 0.05			
<u>White*</u>			
Under 20	8809	3	3.41
20 - 24	24610	13	5.28
25 - 29	37166	9	2.47
30 - 34	29736	10	3.36
35 and over	14490	7	4.83
Contingency Chi - square = 3.90, df = 4, p < 0.05			
* Excludes Hispanic whites.			

Methods for Prevention

When we think about methods for prevention, it may be useful to divide the discussion into philosophies toward prevention and the tools by which we achieve our goals.

Philosophies

Each of us sitting here in this room have our own personal philosophies about our social obligations for the betterment of others. They guide us in our voting behavior when, for example, we are asked to levy a tax on ourselves for some social service from which we may derive no direct benefit. These philosophies influence our willingness to volunteer and our beliefs about what sort of solution is needed for the social problems we see. Governments, too, have philosophies. So do communities.

When we view behavior as a function of individual choice, without factoring in social variables that curtail the range of options an individual can choose from, then it seems obvious to push health promotion strategies that encourage individual action. We forget that some people can not afford to be healthy. Recently, the Nutrition Council recommended five helpings of vegetables a day. When I read this I could not help thinking about my mother, who survives on Social Security and assistance from her adult children. She lives in the Midwest, where in the winter months, fresh vegetables are trucked in from California and Mexico at a very hefty price to her as a consumer. The Nutrition Council, I'm sure, viewed their responsibility as the giving of nutritional advice.

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group's world view. In conducting AIDS education in some African American communities, one must be sufficiently knowledgeable about the debates on the origins of AIDS and the conspiracy theories. This may seem like a simple task, but to be truly effective, it means being knowledgeable about the history of chemical warfare and the role of federal agencies in such warfare; it means knowing something about the history of African Americans and medicine in this country; it means facing up to the reality of benign neglect; it means, when the media decides to cover the Tuskegee syphilis experiment, being prepared to discuss the possibilities of this occurring in relation to current AIDS research, such as the vaccine efficacy trials.

HIV interventions should become a part of festivals, celebrations, and events in the African American community that are geared toward the general population. Recently I attended the African Market Festival. Nowhere did I see information on HIV prevention, but I saw all the things associated with Afrocentric pride, and a promotion of health would have been in keeping with the activities of the Festival. Health promotion in the African American community can not merely be about telling a person what to do, and what will happen if they don't follow our health advice. Many African Americans live in dread of far greater immediate calamities in their lives than HIV infection or even dying of AIDS.

Health promotion must become a more central part of the Black agenda. Responsibility for this lies both within and outside of the African American community. Those interested in HIV health promotion must learn to spend dollars on promotions by working together with community-based institutions, such as African American newspapers and radio stations.

Rarely have I seen the State of California work in partnership with one of our largest community institutions, the Black Churches. One example of the power of such a program is in New York where there is the Harlem Week of Prayer, a cooperative action between the Black churches of all denominations and AIDS educators. For that week, AIDS educators at no charge conduct a variety of prevention programs. While some events are merely one shot activities, others result in the development of ongoing programs. Nationally, Black churches have shown a modicum of success in health prevention efforts such as hypertension screening, smoking cessation, and nutrition. It is important that we begin to foster those partnerships here in California.

While it is difficult to ask the Black community to put one more issue highest on its very, very long agenda of things that really need to be done, the demands of health prevention efforts could be lessened by the addition of resources to allow the community to respond to the HIV epidemic. The White gay community has been able to wage an effective battle against HIV disease through the assistance of many people in that community coming forth and being able to volunteer their time. The White gay community represents an affluent segment of American society. This is not the reality in the African American community. Yet private industry, health care organizations, and others can help through mobilizations of its workforce to donate time. Many large companies have volunteer groups whose time is donated by the company to provide services. Currently in Los Angeles, it is almost impossible to get individuals trained as pre- and post-test counselors. The State has passed the buck to the County, and the County has designed a program giving preference to those who work in County facilities. We have no way to get volunteers who want to become counselors trained, thereby limiting ways in which we can harness the few who have come forth. We must think creatively as to how to enlist the volunteer resources necessary to assist the African American community in its health promotion efforts. We can not expect that something else on their agenda will be moved to a lower priority without additional resources.

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Recommendations

1. Development and implementation of an Afrocentric HIV prevention curriculum
 - a. Implement in-state training for pre- and post-test counselor certification
 - b. Establish as a guideline for all HIV post-test counseling with African Americans
 - c. Mandate as training for all state and county employees working with African Americans
2. Mobilization of volunteer force through private and public donations of salaried employees' time
3. Launch a statewide HIV media prevention campaign through:
 - a. African American newspapers
 - b. African American radio stations
 - c. Cable and public service broadcasting stations
 - d. Use of African Americans to deliver the messages
4. State Office of AIDS should support and develop partnerships with infrastructures crucial to HIV prevention efforts in the African American community:
 - a. Partnership with African American churches
 - b. Partnerships with regional African American sororities, fraternities, civil rights and social groups
 - c. Partnership with African American celebrity and sports organizations
5. Continued availability of anonymous HIV antibody testing for African American community
6. Increase HIV education in the general African American population
7. All HIV surveillance and research data collected by state agencies must include reports by gender, risk behaviors, and ethnic/racial groups that are separated by subpopulations

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