

**Governor's Advisory Council on HIV/AIDS
HIV in the Black Communities of King County Forum
September 18, 2007
Findings and Recommendations**

Background

The Governor's Advisory Council on HIV/AIDS (GACHA) conducted a public forum on September 18, 2007 to focus on emerging HIV/AIDS epidemiological trends within the black communities of King County, as well as to discuss existing prevention and treatment services and new prevention strategies with the potential to reduce infections. (A forum agenda and complete list of participants is attached.)

Summary of Key Findings

Blacks (both native-born and foreign-born) in King County have infection rates nearly three times higher than whites (1.3% vs. 0.5 %.)

HIV cases among native-born blacks are level; while cases among foreign-born blacks are rising.

The majority of foreign-born blacks reporting HIV infection come from Eritrea, Ethiopia and Kenya. It's not known if the infections are occurring in the immigrant's native countries, or in the U.S. Within these immigrant communities, the rate of infection is higher (1.8%) than in the black community as a whole (1.1 %.)

Most native-born black cases are among men who report sex with other men. Foreign-born black cases are different in that most only report heterosexual behavior, although foreign-born blacks also have higher rate of infections where the mode of exposure is unknown.

There are no biological explanations for the higher rate of infections among blacks. Nor do blacks engage more in traditionally recognized risky behaviors, such as unprotected anal or vaginal intercourse, or IDU drug use.

Multiple studies suggest the disparity may, in part, be due to differences in the sexual behaviors of some blacks who report having more overlapping sexual partners at one time, which researchers describe as concurrency.¹

¹ *Disparities in HIV/STI: An Historical Overview of Trends and Explanations*, Martina Morris, PhD
Reducing HIV Disparities: Sexual Concurrency in African-American & African-born Populations, Ann Kurth, PhD

A new prevention message of "one partner at a time" (or what was promoted in Uganda as "Zero Grazing") may be as important as the more traditional messages such as abstinence and condoms.

Native-born blacks aren't fully accessing current services for a variety of factors, including: the lack of insurance and basic health care; the perception that HIV services aren't readily available, culturally sensitive, or trustworthy. Many gay blacks are difficult to reach with messages aimed at the African American community, because they do not identify with African American culture.

Foreign-born blacks aren't fully accessing current services for many reasons, including: the lack of insurance and basic health care services; not enough written information in appropriate languages; not hearing about HIV or being offered HIV tests from physicians; the fear of deportation; the fear of HIV stigma and the loss of social support within their communities, which, generally speaking, don't recognize that HIV is a problem within their communities in the United States, not just Africa.

Progress is being made in the faith community to raise awareness of HIV/AIDS through both increased leadership from the clergy and a commitment from more congregants to take ownership of HIV issues but more work remains to be done.

Community involvement is the key to success in both prevention and treatment.

Recommendations

- **The Department of Health shall determine the feasibility of assessing whether the higher infection rates among foreign-born blacks is representative of a broader statewide trend and report its findings back to the council at its earliest convenience.**
- **The Department of Health shall work with the King County Health Department to best determine whether infections within the immigrant African community are occurring in the immigrant's native country, in the U.S., or both.**
- **GACHA supports ongoing research efforts to further determine the causes of concurrency and develop appropriate prevention strategies and messages to address the racial disparities in HIV infections. Such efforts must be developed in partnership and collaboration with the affected communities.**
- **GACHA, in conjunction with black community organizations, should further explore what prevention and care efforts have and have not worked, to come up with new ideas and strategies aimed at strengthening future efforts.**

- **GACHA reaffirms its support of CDC guidelines for routine HIV testing in all medical settings, particularly those serving minority and immigrant communities, such as Harborview’s International Clinic.**
- **UWAETC (University of Washington AIDS Education Training Center) is encouraged to provide more education on risk assessment and HIV testing to providers serving minority and immigrant communities.**
- **GACHA recommends the Governor increase racial diversity on the council.**

Complete Findings

Blacks (both native-born and foreign-born) in King County have infection rates nearly three times higher than whites (1.3% vs. 0.5 %.)

HIV cases among native-born blacks are level, while cases among foreign-born blacks are increasing. The majority of foreign-born blacks reporting HIV infection come from Eritrea, Ethiopia and Kenya. It is unknown whether the infections occurred in Africa before foreign-born blacks arrived in the state, after their arrival, or both. Within these immigrant communities, the rate of infection is higher (1.8%) than in the black community as a whole (1.1 %.)

Most native-born black cases are among men who report sex with other men. Foreign-born black cases are different in that most only report heterosexual behavior, although foreign-born blacks also have a higher rate of unknown infections.

There are no biological explanations for the higher rate of infections among blacks. Nor do blacks engage more in traditional risky behaviors, such as unprotected anal or vaginal intercourse, or IDU drug use.² Black-White disparities in sexually transmitted and many other diseases pre-date the arrival of HIV/AIDS and have persisted for many years.

Multiple studies suggest the HIV disparity may, in part, be due to differences in the sexual network structure of some blacks who report having more overlapping sexual partners at one time, which researchers describe as concurrency. In King County, 49% of African American men reported a concurrent relationship compared to 28% of white men.³

² *Disparities in HIV/STI: An Historical Overview of Trends and Explanations*, Martina Morris, PhD.

³ *Reducing HIV Disparities: Sexual Concurrency Communication in African-American & African-Born Populations*, Ann Kurth, PhD.

This would suggest that a new message of "one partner at a time" may be as important as the more traditional messages such as abstinence and condoms.

In all cases community involvement is the key to success.

Community members aren't seeking services because (among native-born blacks):

1. The services aren't perceived to be culturally sensitive.
2. Related to (1), there is no place to go where "people look like you and talk like you."
3. Lack of trust in providers (also related to (1).)
4. A communication barrier of "being told what to do" with no opportunity for discussion.
5. Targeted messages can be problematic, because many gay blacks don't identify with the African-American community.
6. Rates of depression are higher resulting in people not seeking services.
7. There is a lack of health insurance and access to basic health care, as well as a prevalence of thought that you don't go to the hospital, or see a doctor, unless you're sick--thus testing becomes problematic.

Community members aren't seeking services because (among foreign-born blacks):

1. Language barriers, including lack of written information in appropriate language.
2. Lack of appreciation in the community that HIV is a problem in African American communities in the US--not just in Africa.
3. Fear of HIV stigma and loss of social support in their communities.
4. Fear of deportation.
5. Not hearing about HIV from their physicians, or being offered routine HIV tests.
6. No psycho-social support groups within these communities.
7. Competing priorities in life.

Progress is being made in the faith community to raise awareness of HIV/AIDS through both increased leadership from the clergy and a commitment from more congregants to take ownership of HIV issues by initiating and sponsoring community events aimed at increasing awareness, reducing stigma, and encouraging testing.

The number of voices in the clergy speaking about HIV has grown from just one to two several years ago to over 60 who are now actively engaged.

Congregants are sponsoring plays and taking part in AIDS walks. Community members increasingly are requesting that HIV/AIDS information be presented at health fairs. Requests for presentations by the AARTH (African American Reach and Teach Health) ministry, for example, grew from zero to over ten requests last year.

While this still represents only a small change, there is a need to recognize the groups which have stepped forward to take ownership of the issue and reinforce them--not just complain that we need more involvement.

The faith community wants more resources but has difficulty obtaining them and partnerships often aren't deemed to be culturally appropriate, such as proposed efforts to provide HIV testing through Gay City.

Observations from the community panel:

1. More outreach to the foreign-born black community is needed.
2. The mobile HIV testing unit with culturally sensitive services, including counseling should be reestablished.
3. There is a need for more and stable funding for prevention and education programs.
4. Different, more creative funding mechanisms are needed, other than what exists today where it's all-or-nothing, win-or-lose, which sees the same groups competing for the "same pennies."
5. More long-term funding is needed for projects which realistically will take 5-6 years to achieve, instead of the one-year plans being made.
6. A more holistic approach which addresses all the health care needs of the community is necessary.
7. The black media needs to be more involved.
8. "More of the same" prevention messages won't work...something new is needed but before something such as "one partner at a time" would work, you need to get people to talk about sex and admit they are having sex at-risk people.

Observations from community members:

1. More funding is needed: it seems that just as HIV began to explode in the minority communities, funding was cut.
2. All health disparities within the black community must be addressed.
3. Native American people are undercounted in the HIV #'s and are not getting the services they need.
4. Need for universal health care; HIV is just one disease.
5. Need more local HIV-positive black role models.
6. HIV drugs are too expensive and should be made cheaper.
7. In King County there is a perception of too few people dealing with African-American men who have sex with men; there is need for more staff.
8. GACHA needs more black members.

ADOPTED November 13, 2007