

## Cultural Diversity and Sexuality/AIDS Information and Education

### CONSIDERATIONS FOR REACHING THE LATINO POPULATION With Sexuality and HIV/AIDS Information and Education

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#### **T**he Diversity of the Latino Culture

It is difficult to speak of sexuality issues among Latinos in the United States as if they were just one homogeneous group of individuals. The U.S. Latino population (see definitions on pages 4 and 5) — estimated to be more than 20 million people — includes individuals who speak many different languages and come from different regions, races, classes, and cultures of the Americas.

Although the attitudes and the ways they perceive one another may differ among various Latino groups, similarities have also been noted within groups, and between groups, that have resulted in individual and group stereotypes. For example, many Latin American mountain people consider the morality of coastal and island Latinos as "loose," while many of the latter regard the former as "puritanical"; many Latino whites, who publicly appear to live according to more conservative European moral traditions, consider black and racially-mixed Latinos as "overly erotic," and often simply ignore Indians as "asexual." Numerous myths and stereotypes are found among Latinos, as within any group of individuals. It is important that these subtle cultural forms of differentiation not be missed by North American service providers, as they may be the nuances that allow for the development of educational strategies that will effectively reach the Latino population.

As a Latino speaking to North American audiences, it remains forever difficult to speak of Latino sexualities without feeling that I am exposing my own communities to an unkind gaze, and that I am only emphasizing

the negative: that is, that which is most difficult for North American professionals to understand; that which gets in the way of their work; and that which they must come to understand if they want to be clinically educated and educationally effective.

However, North American culture is suddenly having to become deeply acquainted with its Latino cultures because of the AIDS crisis. Although this is a terrible way to get acquainted — within a framework of illness and possible death — no one can wait for the melting pot theory to become a reality nor can Latinos "North Americanize" overnight, so-to-speak, so that they can fit neatly into North American culture-bound strategies. Latino sexual attitudes and behaviors must be looked at if one hopes to work closely with these communities, and strategies must be tailored to align with Latino cultural imperatives. Only then will Latino sexuality and AIDS education interventions actually begin to connect.

When one looks at Latino communities in the United States within the context of the AIDS crisis, one is confronted with many crucial issues: AIDS and unsafe drug use; AIDS and unrecognized and unprotected male bisexual behavior; AIDS and women; and AIDS and the newborn. These issues arise out of a socially complex framework of urban — and often immigrant — poverty, a framework that creates a breeding ground for HIV/AIDS. The focus of this article, however, will be on the particular Latino and Latina attitudes and behaviors that must be understood if researchers, educators, and counselors hope to effectively reach this population with sexuality and HIV/AIDS information and education.

## **General Sexual Attitudes and Behaviors of Latinas and Latinos**

The general U.S. Latino population is mostly sexually conservative: direct sexual talk in public and private is still basically unacceptable among Latinos and sexual roles are still experienced as extremely polarized.

Latinas, for the most part, continue to be expected to fulfill a role often described by Latina feminists as bordering on the "culturally schizophrenic": they have to be virginal, but seductive; fragile (in need of male protection), but strong (so as to bear many children); and privately wise (as they are the first and, sometimes, only teachers of some of our poorest children), but publicly humble (as they should not show themselves as more publicly assertive than men). Latino men, in contrast, are not only generally free from the requirement of premarital virginity, but are expected to be "sexually experienced" before marriage. Thus, while males are encouraged to develop their sexual skills through a collection of premarital sexual experiences, women are expected to participate sexually, as it were, from instinct, with the verbal coaching of another — perhaps older — female, or they are expected to be initiated into an active sexual life by a male partner who is seen as an experienced teacher.

Men are most often conceived of as unable to control themselves sexually. Therefore, if a man is unfaithful to his wife it may be tolerated as the inevitable lot of women. The wife may don a martyr's attitude (possibly enhanced by her conservative Roman Catholic background) and keep the sanctity of the family home intact as long as no one speaks of it in public. An evil, seductive, larger-than-life "temptress" (Latino popular entertainment frequently abounds with voluptuous and sexually enticing vedettes) may also be blamed for luring the victim husband away from marital fidelity.

The latter social attitude is one of great irony because most low-income Latinas do not socially own their sexuality; it is owned, most commonly, by the males of their extended family group. Their fathers, uncles, brothers, and cousins "administer" their virginity, give them away in marriage, and take them back. Within this traditional system, the only women who appear to own their sexuality — and only to some degree — are sex workers (prostitutes).

Since, in Latino communities, women's sexuality is considered to be both extremely precious (because of its childbearing quality) and extremely dangerous (because it can, if unleashed, "enslave" men), its manifestation is regarded as something that must be dominated, otherwise it will be destructive to society.

## **Childbearing and Birth Control**

It is important to understand that childbearing has a different meaning among the poor than among those who are more affluent. For the poor, in a society where they own little or nothing, their only source of wealth is their children. Indeed, in the urban areas of the first world, children are still considered to be the wealth of the poor, even though the agricultural and early industrial attitudes which saw children as free labor have

been left behind. For Latino women and men who live in the first world within third world pockets, childbearing is often the only way they have to prove that they are socially productive and thus worthy of respect. Often stripped of everything else, and living in environments where there is little access to adequate housing, education, nutrition, and employment, they are left only with their most basic means of production — their fertility.

Latinas are usually held solely responsible for birth control. Traditionally, if they do not wish to get pregnant, they, not the men, must search for adequate protection. That is why the current condom campaign against HIV infection has had such limited success within Latino communities. Latino men have never had to worry about birth control devices. In fact, if a Latina, who is single, becomes pregnant, it is not unusual for the community to accuse her of secretly and maliciously trying to bind

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## **Some Guidelines for Researchers, Educators, and Counselors When Dealing With Latinas**

**#1** There are numerous Latinas involved in social work, teaching, nursing, casework, and other service professions. They should be consulted — possibly as part of advisory or focus groups — in the development of any formal HIV/AIDS outreach to their communities.

**#2** Latinos must be reached with information and education at the same time that Latinas are engaged. This will reinforce any kind of assertive safer sex negotiation that Latinas and Latinos may attempt to initiate at home and will help to create a safer environment for the introduction of such information.

**#3** Public health educators and clinicians must be aware, that in spite of instances of Latino male oppression, Latinas traditionally have considerable nonpublic, nonverbal authority *within the family*. As those who cook and feed the family, provide folk health care, teach the infants, and clean the house, they have the authority of those invested with the care of the "sanctuary" — the family home. However, one-third of all Latino households are headed by women with permanent or partially absent partners/fathers, which is increasingly placing such women in new and growing positions of authority beyond the family home. This is not yet recognized and supported by their society — a society that still lives under the illusion that women are in the same place as they were before. Educators should be aware of both traditional and new forms of female authority.

**#4** Latinas are more ready to think of their family's health than of their own; they will sacrifice it for them. When stressing with Latinas the importance of their own sexual protection against HIV, educators should note their roles as mothers and caregivers, and should emphasize that by taking care of themselves they also will be taking care of their children and other family members.

some man through her pregnancy.

For low-income Latinas, sterilization, which demands only a single medical intervention, has often been the most accessible form of birth control. The mass sterilization of low-income Latinas, however, has become a highly controversial issue. To turn sterilization into the only culturally accessible alternative is considered simply criminal by many — not to mention the lack of, or inappropriate, counseling given before and after surgical intervention, and the undue pressures exercised by "males in white robes" on poor and often illiterate women. Although many Latinas have found themselves relieved of the burden of innumerable unwanted pregnancies, there has also been the sad experience of those who have returned to their communities — which place the woman's worth as a human being on her ability to procreate — with traumatic consequences.

The lives of Latinas have always been undervalued in comparison to the lives of Latinos. Therefore, one must remember when approaching HIV-positive Latinas who are pregnant, with the subject of abortion or with the recommendation that they not have any more chil-

dren, that part of their culturally-determined mission in life is to assure the life of the male and to provide him with existential continuity — that is, to provide him with a male baby that will inherit and pass on the family name. In addition, because a woman's life is traditionally defined by the presence of her male partner, she may wish to have, in the form of a child, a reminder of him so that she can feel she has a graspable part of him if he should die prematurely of AIDS.

It is also important to understand that Latinas are the quiet pillars of the Latino family. As such, they learn to take care of everyone else, but themselves. They, for example, often are willing to eat less in order to assure that their husbands and children will be able to eat enough. That is why a disease that infects them may be so dangerous. If Latinas are impacted on by HIV/AIDS, the entire family's health may crumble.

### **Sexuality and AIDS Education in Latino Communities**

There is almost a total lack of adequate sexuality education in U.S. Latino communities. In some areas, Latino leaders have begun to publicly address the subject of

sexuality *only* because of the fear of AIDS. This is very dangerous. To present sexuality education under the umbrella of fear of AIDS is to equate, in some ways, sexuality with illness and death. This perpetuates a fear of sexuality within groups where it is already shrouded in an atmosphere of great mystery. In addition, private and public experiences of sexuality within Latino communities have not yet been fully studied.

Clinicians serving Latino communities should be aware that women may walk into their offices pushing a heavy baby carriage, pulling an infant by the hand, and pregnant with a third child, but not know even the basics about sexuality education. As Dr. Yannick Durrand of the Brooklyn AIDS Task Force observed while training hospital personnel in New York: "For many low-income women of the third world, sex is something that happens to them in the dark and in silence."<sup>1</sup> Many Latinas do not talk about sex, even with their male partners. Often, they find it is even too embarrassing to acknowledge that they are actually there — fully conscious and present — during "the act," and/or that their "hot Latino lover's" sexual performance may leave something to be desired.

Latino society does communicate abundantly about sexuality, but it does so in indirect and nonverbal ways. It is not uncommon to hear that fathers and uncles have taken their newly pubescent male relatives directly to sex workers to learn about sex without any prior discussion with them about basic sexuality. This stark cultural device helps them avoid talking about the subject. "We learn by doing, not by talking," is a common saying among Latinos.

Moreover, many Latino communities still believe that good and virtuous women do not talk about sex. This is why so many young Latina public health educators report that when they approach Latinos to speak with them about sexual subjects, the men, believing that they are "coming on to them" behave as though they are "turned on" and, in turn, "come on" to the women. Direct sexual talk is tolerated as something that only men, who may or may not be under the influence of alcohol, publicly engage in, often with sex workers or within the permissive atmosphere (a joking or seductive atmosphere) of a party or an all-male group.

Latinas, because of their training in passivity and submission before male authority, have been thought of as easy targets for public health education strategies. They have, therefore, been invited out of their homes into friendly and apparently harmless local community centers, or clinics, where condoms have been distributed to them — like cheap candy — as part of a one-time AIDS prevention effort. The local public health "minority" outreach worker leaves the presentation happy because his or her generic condom box is empty and goes home believing that s/he has done a great job. But, what the outreach worker may have indeed done, is to place those women at risk of being battered.

As stated before, many Latinas basically have no authority over the sexual act, so to provide them with condoms without preparing their male partners as well, and to pretend that they will be able to take them home and

## Some Definitions That May Be Useful

**Minority:** "*Few in number.*" This term is commonly used to describe black, Latino, Native American, Asian, and other ethnic groups in the United States. It is currently regarded by many as an oppressive term that connotes disempoweredness and poverty. Its use is increasingly thought to be inappropriate in areas where such ethnic groups' presence is numerous, strong, and organized.

**Hispanic:** "*Spanish speaking.*" A language term frequently misused in the United States as a racial term to label the peoples of Central and South America and the Caribbean/Atlantic region who have immigrated into English-speaking North America. Its racial use is inappropriate; it says absolutely nothing of the race of the people it attempts to describe. That is, it does not say whether the person labeled "Hispanic" is black, white, Indian, or racially-mixed. In fact, the person labeled with this language term, such as a Brazilian (whose native language is Portuguese) may not even speak Spanish. As a term, it is increasingly thought to be discriminatory by many Latinos, as it connotes poverty and lack of education to many of them.

**Latino(s):** When used in its singular form, Latino means a male Latin American. When used in its plural form, Latinos may also mean two or more Latin Americans, both men and women included. It is currently being presented as the "politically appropriate" term for anyone referring to this community but its use has not yet been accepted by all. Many Latinos themselves prefer the term Hispanic, as it is more familiar and does strictly refer to those in the Americas who speak Spanish. However, the term still creates confusion — in Europe it is used to describe all peoples and languages derived from Latin: Italians,

*Portuguese, Spaniards, and the French are also "Latinos."*

**Latina(s):** When used in its singular form, it means a female Latin American. In plural form, it means two or more Latin American women. Many people, particularly lesbians and feminists, are promoting the use of this term as more sensitive: Latinas deserve to be specifically named and addressed and should not be hidden within the male plural term.

**Latin American:** Those people of the Americas who have Latin roots, most often understood as Spanish roots. This term is commonly used to designate the peoples of Central and South America and the Caribbean/Atlantic region. It is this author's belief that the best attempt at encompassing the Latino communities of the United States is one that researches and names the national and racial background of the particular U.S. Latino community one wishes to address: the Cubans in Miami, San Juan, or Union City; the Puerto Ricans in Manhattan or the Bronx or the Colombians in Queens, New York; the Haitians in Miami; the Salvadoreans in Washington, DC. Or we may speak of Central Americans or South Americans or Caribbean peoples, who may be white, black, Indian, or racially-mixed between two or more of these races.

*It is also interesting to note how often Latinos, who have been born in the United States, will refer to themselves as "Hispanics," whereas they will refer to newly arrived Latinos as "Latin Americans," considering them below themselves as they are not yet fluent in English nor do they yet have permanent resident status. On the other hand, many Latinos arriving in the U.S. will refer to themselves as "Latin Americans" and to the already-settled Latinos as "Hispanic," considering themselves to be more culturally pure while "Hispanics," they feel, have lost all, or part, of their original Latin American culture to North American cultural influences.*

playfully place them on their male partner's erect penis, is possibly to be encouraging domestic violence. The men may feel castrated by their women who all of a sudden have assumed intimate authority (which they have never had before) over the core of their male partner's masculinity — his erect penis — when he is at his most vulnerable — naked and horizontal.

At the same time, to give a condom to a Latino and pretend that he will use it with his Latina wife, without first educating her, may lead his wife to feel that she is being treated like a sex worker, or it may suggest to her that her husband has been unfaithful and has caught some very "well-deserved" sexually transmitted disease from which he is now trying to protect her. Contraception is basically unpopular with everyone in Latino communities. However, if there is some chance of contraception being used, it might be with a sex worker; a sex worker is possibly the only woman with whom a man may avoid having children. It is also common for men to resist using condoms with a sex worker as well, as she may be a total stranger to him and he may not be concerned about her health, which could put a whole family at risk if she contracts HIV. It should be noted that sex workers in Latino communities in the Americas — and anywhere else where there is poverty — are often mothers who engage in prostitution sporadically, and not full-time, in order to afford food and shelter for their children and themselves.

No sexuality education strategy will be complete unless both partners are fully educationally engaged at the same time. This may mean having each in separate rooms with same-gender sexuality educators or counselors, and then reuniting them afterwards in order to begin to establish some dialogue between them. Both would then know that the other possesses an equal amount of information and that they have, momentarily, been made equal by the information received during the educational interventions.

Their sexuality is one of the few areas in which low-income Latinos still feel they have some control over their lives. Yet, public educators have proceeded to open this last sacred door by storm — because "we are in a health crisis" — and have then assumed the right to tell these people not to engage in sex or how they should do it. Educators or counselors, developing AIDS-related condom strategies for Latinas and Latinos, must understand the larger social context and then must ask, if they really want to be effective, what they plan to give these people for what is being taken away. Are they really "saving their lives" when it is at the cost of total disempowerment? Don't the recipients have the right then to ask if their lives will be worth living after paying such a high price?

#### **AIDS and Unrecognized Latino (Male) Bisexual Behaviors**

It is my belief that when we speak of Latino bisexuality issues within the AIDS crisis, most of the time we are not addressing true Latino bisexuality, but closeted Latino homosexual behavior or the bisexual behavior exhibited by Latino heterosexuals because of machismo. Thus, the

real Latino bisexual is lost in the shuffle of understudied and misunderstood general Latino sexual behavior. Therefore, in this article, I am not going to deal with bisexual identity, but with those sexual behaviors that cause the focus on true bisexuality to be lost in most studies and educational approaches.

Latino bisexual behavior may prove to be the entrance door for HIV into mainstream Latino communities in the United States and into Southern Latino societies, if public health educators, here and abroad, do not recognize it and take appropriate action immediately.

When one begins to look at different male bisexual behaviors within U.S. Latino communities, one has to start by distinguishing between sexual identity and sexual behavior. Researchers should note that often how Latinos (males) self-label their sexual identities has little or nothing to do with their actual sexual behaviors. Within many Latino cultures, there are many publicly self-labeled male heterosexuals who manifest private bisexual behavior. My first recommendation for any new research, education, or social service strategy is to place the issue of sexual identity in the background and bring the issue of sexual behaviors forward to guide the new approach. Individuals should be asked what is it that they sexually do — both consciously and unconsciously — not who do they think themselves sexually to be and how do they sexually label themselves.

By unconsciously, I mean that within many a socially oppressive heterosexual environment, forms of sexuality, such as homosexuality and bisexuality, often show their faces briefly, and only when individuals are under the influence of alcohol or drugs. Suddenly, sexually-closeted males may become "overly affectionate" with other males or may go on to show clear homosexual or bisexual behavior. This is, in part, why so many Latinas regard the undue consumption of alcohol by their male partners as something, not only unpleasant and addictive, but dangerous and sinful, as they suspect that this type of behavior (as well as heterosexual promiscuity) might be encouraged and induced among their male partners. While some individuals hold on to the need for personal control in order to survive within their societies, others sporadically let go of this control as a way of surviving. Thus, a sexually-closeted man may get drunk in order to let out that oppressed, but important, part of his sexual identity that must be fulfilled in some way — now and then — in order for him to survive.

It is difficult to talk about bisexuality among Latinos in the United States because these communities, in general, consider it socially improper to address any sexual matter directly. Also, Latino cultures do not have the appropriate, direct verbal language to do so — although they do have their indirect and nonverbal ways. Bisexuality must be approached, therefore, from within the general context of Latino sexualities, as it can only be explained in relation to this broad Latino sexual framework.

### *Contributing Cultural Factors*

Within Latino cultures there are a number of factors, which cannot be explained in detail here, that may lead to bisexual behaviors. However, some of these factors will be mentioned briefly.

*Gender roles* continue to be very polarized among Latino people and often produce very harsh role expectations. In general, sexual liberation tends to open up heterosexually-polarized societies and create more sexual options. But, many Latino homosexuals or bisexuals, living within communities that are still heterosexually conservative, are culturally forced to opt for one of the two polarized heterosexual gender roles, and they are forced to adopt public heterosexual male personas while privately manifesting homosexual behavior. For them, unlike many homosexually-inclined men of first world urban societies, there is no middle-of-the-road option. Bisexual behavior is thus culturally engendered.

*Coming of age rituals* are celebrations mostly thought to occur in Africa or the Pacific islands, but Latino communities still indirectly mark the coming of age of their male youth by tolerating, if not nonverbally encouraging, a more than usual broad range of sexual activity and experimentation. To play with sexually penetrating another male, for the sake of practicing a newly found, socially dominant role, is not such a taboo at this time.

*Machismo* is still a strong underlying force in most Latino communities and — as the primitive attitude and philosophy that it is — encourages the male to be sexually dominant, particularly over the feminine (whether feminine female or feminine male). Also, there still is a mystique that homosexual men are not really men. This mystique, tied to the belief that the "super-macho" man is one who not only penetrates/domesticates women but other males as well, encourages bisexual behavior in extreme cases of machismo.

Not enough is said of the role of *poverty* and bisexual behavior — it is as if poverty-related sexual behavior only occurs in developing countries. Poverty can lead heterosexual Latinos to engage in bisexual prostitution in order to put themselves or a relative through school or simply to pay the rent and buy food for their families. Or, it may mean that a homosexual Latino — who does not have the financial means to physically leave his heterosexual family home to live an independent homosexual lifestyle in his own home — will have to remain in his family's home. Under constant family pressure, he may eventually marry, yet continue to manifest his homosexual behavior privately, while he behaves, as a whole, bisexually.

*Strong heterosexual family influence* is also a part of the many cultural factors that induce bisexual behavior. For many Latinos, choosing a homosexual lifestyle may mean becoming totally alienated from their families. In societies where the abandonment of the family is culturally inconceivable, this forces some homosexuals to lead double, i.e. bisexual lives.

The influence of *drug addiction* on bisexual behavior is not generally acknowledged. Some Latino self-labeled heterosexuals, however, do engage in bisexual prostitution in order to support their drug habits.

## ***Some Guidelines for Researchers, Educators, and Counselors When Dealing With Latino Males***

- #1** Unlike the North American gay community, which in large and fairly liberal urban centers can be easily found in particular sectors of cities and towns, the Latino who exhibits bisexual behavior is found everywhere in Latino communities. Therefore, any research study or educational strategy that wishes to reach him must aim at all the places where he lives, works, and socializes, such as gay and straight bars, gay and straight cruising areas, community centers and clinics, public transportation, churches, factories, public bathrooms, Latino neighborhoods and stores, and so forth.
- #2** Do not presume that Latinas do not know or suspect that their male partners are engaging or have engaged in same-gender sexual behaviors. There is, however, a significant cultural difference between knowing this and admitting it to strangers who are outside of the family and community.
- #3** Realize that Latino bisexual behavior means "AIDS within the Latino family." As the most difficult place to introduce a condom is in an existing, ongoing relationship, particularly if it is an old one, a Latino man, engaging in bisexual behavior, may be more likely to introduce a condom into a sexual exchange with his new male sexual partner than with his longstanding wife. Nevertheless, if he is extremely closeted and his same-gender sexual exchanges are anonymous, he may not care about using condoms with male strangers; in fact, he may not use condoms with either the stranger(s) or his wife.
- #4** The question that must be asked of the Latino, who does not self-identify as a homosexual nor as a bisexual but is suspect of same-gender unprotected behavior, is not whether he has had sexual intercourse with another man, but whether he has had sexual intercourse with: a younger man; an effeminate man; a man dressed as a woman; a woman who was really a man or who turned out to be a man; a homosexual; a friend; or a (male) stranger whom he met at a bar (after drinking too much). One must try to "soften" the male identity of the partner, as that is just how this Latino perceives it — that is, not very strongly. Also, try to place him verbally "on top," that is, ask him if he penetrated someone else. There is a Latino mystique that the one who performs the penetration is the real male or, at least, maintains his manhood intact, while the one who is penetrated loses it and is not a real man. (In at least one South American country's army, there are different penalties for men found having anal intercourse: the passive partner receives the stronger sentence. In this case, institutionalized law maintains this sexual cultural myth.)

### *Types of Bisexual Behaviors*

Some of the types of bisexual behaviors that I have encountered while working with and traveling through Latino communities in the United States and abroad are the following:

*The closeted, self-identified, homosexual Latino* is homosexual in his self-identity but bisexual in his behavior. Though out to himself, he lives a homosexually closeted life because within his heterosexually-polarized community he cannot bring himself to adopt a transvestite role or that of a very publicly effeminate male — his

society's most common, and perhaps only, experiences of those who are openly homosexual. Yet, he may also be closeted for the reasons listed above (especially poverty and family influence).

*The closeted, latent-homosexual Latino* may define himself as heterosexual, but he is haunted by his own attraction to men which humiliates and angers him. He may engage in same-gender sexual behaviors only under the influence of alcohol or other drugs, and will explain his behavior later, if he remembers it at all, as the strange consequence of such influences. In between episodes, he may be a strong public homophobe. Sporadically bisex-

ual, he does not admit to homoerotic feelings, much less to a homosexual identity, yet he may actually be the one who is penetrated during infrequent same-gender exchanges. There are many levels to latent homosexuality. A Latino may find himself close to a level of self-acknowledgment, but may still hold back because of his hate for, and/or fear of, a homosexual identity. Or, he may assume that he is bisexual in identity, and may deal with his homosexuality, as it were, "half way."

The "super-macho," heterosexual Latino allows himself to have sexual intercourse with homosexuals, because he does not truly consider them to be real males; they are "pseudo-females." It has become very trendy, within the evolving lingo of North American urban public health, to try to engage him with the phrase "men-who-have-sex-with-men." But even this expression will not do it. The problem, here, is that often this heterosexual Latino, not only will not admit that he has had sexual intercourse with other men to his interviewers, but he will not admit it even to himself. My belief is that culturally he does not completely perceive homosexuals as other males, but perceives them rather to be a "third sex." His common perception of them is as transvestites who are involved in sex work, as those who are involved in the seductive bar glitz of female impersonators' shows, or as those who are involved in the exclusive women's world of beauty parlors. He observes such men walking, talking, and behaving like women, so he experiences them, in some ways, as women. He is therefore made "gender-blind" by his culture. (How Latino transvestites feed this view of themselves as women is material for another article.)

Here, then, is a sexual/social reality where Latino homosexuals, bisexuals, and heterosexuals all have sexual intercourse with each other, within Latino cultures that hide these behaviors from the rest of society and, most importantly, from each other. And, regardless of any kind of private psychological denial of same-gender behavior, many of the men who are homosexual or bisexual may have a female partner and may have fathered children. Having a wife or girlfriend nearby helps them to hide the reality of their same-gender sexual behavior, and to avoid the personal challenge that such behavior presents to the unexplored sexual identity that they hide from society and from themselves.

#### "Minority" and "High Risk Groups"

I would like to note here that I cannot help but be concerned with the issue of whether articles such as this feed the underlying belief that AIDS is about "high-risk groups" — and that Latinos and blacks are now being profiled as the "new" high-risk groups, just as North American gays and Haitians were initially profiled (and, in many instances, have continued to be profiled) since the beginning of the AIDS crisis. Larger North American society thinks of itself as sheltered from the virus, because it believes that it can still contain its marginal ethnic groups within the compartmentalized label of a "minority" status. This, however, is a dangerous assumption, as it prevents policymakers from creating prevention programs for mainstream society.

Moreover, when observing the progression patterns

of the AIDS epidemic worldwide, I see no reason why North America will not follow their course. And, I fear that we may be writing future articles, similar to this one, on considerations for reaching the various ethnic groups of *mainstream* America on the intricacies of their sexual attitudes and behaviors — the Irish Americans, Polish Americans, German Americans, and Italian Americans, for example — so that culturally-appropriate prevention programs can be designed for them just as we are now trying to do for Latinos, blacks, Asians, and Native Americans.

This article does not, in any way, pretend to cover or exhaust all the issues faced by Latinas and Latinos. Lesbian Latinas and AIDS, and the HIV-risky practice of anal intercourse as a form of birth control among the poor and as a "protection" against the loss of female virginity between young, unmarried Latino couples, for example, still need to be named and discussed. Further research also needs to be done on a number of pertinent issues, including the impact of North American colonization on Latin America and how it has culturally engendered a certain type of Latino gay man — particularly within the so-called third world poor, urban communities that are hidden within first world U.S. cities. Such a Latino regards the Anglo-Saxon race and culture as superior and may be willing to join it — at any cost — which may be through an association with a North American, English-speaking lover, whom he does not want to lose, even if his lover is unwilling to use condoms and is placing him at risk for HIV infection.

#### References:

1. Training given to medical personnel at Downstate and Kings County hospitals in 1989.

*This article is based on information included in the as-yet-unpublished Inventory of Hispanic/Latino Cultural Issues Affecting AIDS Service Delivery in New York, Cultural Sensitivity Series, Training Manual Number One by Ernesto de la Vega.*

## **COMO HABLAR CON SUS NIÑOS SOBRE EL SIDA**

The Hunt Alternatives Fund has awarded SIECUS a \$10,000 grant to adapt and translate its booklet, *How to Talk to Your Children About AIDS* for Spanish-speaking families. The booklet will be available September 1990. We are grateful to the Hunt Alternatives Fund for their support.

# NATIVE AMERICANS, STEREOTYPES, AND HIV/AIDS

## Our Continuing Struggle for Survival

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**A** discussion of the AIDS epidemic among Native American people requires a brief introduction to some of the facts of modern Indian life. Moreover, in order to make sense of the problem of HIV/AIDS among Native Americans, some stereotypes must be laid to rest and the reader must be given a contextual framework within which to place such information.

### The Impact of Stereotypes On Indian Life

The realities of Indian life have been obscured due to centuries of multilayered stereotypes which continue to confound understanding and communication. Vine DeLoria put it succinctly when he said: "People can tell just by looking at us what we want, what should be done to help us, how we feel, and what a 'real' Indian is really like...To be an Indian in modern American society is in a very real sense to be unreal and ahistorical."<sup>1</sup>

Unfortunately, the cigar store, befeathered Indian caricature is still considered acceptable by a majority of non-Indians: for example, it still serves as a mascot for football teams, and it is still used as a model for dressing young children in costumes on Halloween. It is difficult for non-Indians to understand how irritating, depressing, and destructive this type of stereotyping is, and how little it represents the Indian cultures of today.

It is especially damaging to younger Indians, who are struggling with their identities. Try to imagine and understand what it would be like, when one is in school, in one's country of origin, to have one's own history and culture ignored — or, at best, mentioned only in passing. Or, what it would be like, as an adult or young person *never* to be treated as a real person — and to have non-Indian people constantly invalidating your identity because you do not fit their stereotypes. Such behavior toward Indians — as true today as it ever was — is part of what we mean when we speak of "cultural genocide." When these stereotypes get in the way of health professionals providing education, prevention, surveillance, and information, the results can be tragic.

The number and sheer depth of stereotypes about Indians create stress and anxiety for many Native Americans. These stereotypes also create barriers in acknowl-

*"The number, and sheer depth, of stereotypes about American Indians create stress and anxiety for many Native Americans... At the root of such stereotypes is the mistaken view that we are one people. Like Europeans, Native Americans are not one people."*

edging the existence of AIDS in our communities, and in recognizing individuals who have AIDS for AIDS case surveillance.

### We Are Not One People

At the root of such stereotypes is the mistaken view that we are *one* people. Like Europeans, Native Americans are not one people, although our experiences with the outside world have helped to create a pan-Indian identity. One's tribe (nation) — Choctaw, Peoria, Tlingit, Malecite, Arikara, Okanagan, Snohomish, Caddo — is where one's primary ethnic identity lies. Each tribe has developed its own language, customs, and beliefs; each has had a different history; and each has exercised its own strategy for dealing with the relentless invasion of new peoples and with the catastrophic changes that have taken place in their traditional lifestyles.

### How We Are Labeled by Others and By Ourselves

All Native Americans, in our languages, are and always have been "the people." But, among most of us today, "Indian" is the most common term used when we talk with one another in English. Nonetheless, it is important to understand that, until the Europeans arrived and thought they had come upon India, among the indigenous population there were no so-called Indians.

Several terms will be used in this article, interchangeably, for the aboriginal inhabitants of North America, none of which is at all, or entirely, accurate, though all of which have been accepted in American English to some degree or another. "Native American" and "Indian"

will be used in order to avoid the cumbersome and lengthy expression, "American Indian/Alaskan Native," which has several meanings: racial, ethnic, and legal.

The definition of who is, or who is not, an American Indian or Alaskan Native, depends on who is doing the defining. But, in the most general sense, these are individuals who are recognized by an aboriginal nation of North America as citizens of that nation. However, each nation or tribe exercises its sovereignty by defining who its citizens are, and there are no standard rules for what determines tribal citizenship. For example, some tribes require that individuals have a particular blood quantum (see box below); some that their mother is a member of the tribe; and some that they be descended from a base roll of tribal members at a particular point in time.

Congress occasionally has established its own eligibility requirements for specific federal programs for Indians, and the U.S. Census has relied on an individual's own perception of his or her ethnicity. "Federally recognized" American Indians or Alaskan Natives are tribally-recognized citizens of the original nations of North America that have maintained a government-to-government relationship with the United States. Since 1924, Indians have been dual citizens: citizens of the United States, and citizens of the aboriginal nation to which they belong.

#### *We Are of Mixed Racial Descent*

The majority of Native Americans are of mixed racial descent. In 1910, a special census of the American Indian population found that 35.2% of the Indian population at that time were of mixed racial descent.<sup>2</sup> By the 1930 census, 42.4% were "mixed-bloods." Moreover, the number of mixed-bloods varied by tribe. For example, among the Ojibwe (in 1930) only 18.7% were "full-bloods," while among the Pima 97.9% were full-bloods. In 1985, the U.S. Bureau of the Census reported that more than one-half of all American Indian men and

women were marrying non-Indians.<sup>3</sup> Mixed racial descent leads to underreporting in case surveillance. For example, an Office of Technology Assessment report on Indian health (1986) stated that ethnic misidentification was the most important limitation on available mortality data.<sup>4</sup>

Such difficulties have led researchers to believe that there is underreporting of AIDS cases to, and by, the Centers for Disease Control (CDC) in respect to this community.<sup>5</sup> Most case surveillance relies upon the diagnosing physician's report of an individual's ethnicity. The original information may or may not have come from the patient directly. In cases where a physician relies upon skin color or other racial features or on the last name, mistakes occur; it is not always easy to tell by sight or by name, who is or is not Indian. Native Americans, as a group, do not always fit the stereotypical racial characteristics expected by most non-Indians. It has been my experience that even Native Americans who are not of mixed-race often are misidentified as Filipino or Chinese. Also, many Indian people in the Southwest and California have Hispanic last names, and in the state of Washington many coastal Indians have intermarried with Filipinos. The solution to the problem is to encourage Indian people always to report that they are Indian, and to encourage service providers to ask before assuming a person's ethnicity.

#### *We Are Invisible in Our Own Land*

We are invisible in our own land. Many Americans are surprised that AIDS is a problem for our people — or even that we still exist. The realities of contemporary American Indian life are unknown to the vast majority of Americans, partly due to our small population. Since the initial European invasion of North America, epidemics of diseases over the centuries — including smallpox (perhaps the biggest killer), diphtheria, typhoid, cholera, syphilis, typhus, and alcoholism — against which Indians

## "CERTIFICATES OF DEGREE OF INDIAN BLOOD"

In this late twentieth century, American Indians and Alaskan Natives are still being issued identity cards called "Certificates of Degree of Indian Blood" (CDIBs) by the U.S. government. These purport to "document" the amount of blood that an individual contains (here, a nonliquid measure) of an aboriginal tribe (1/2, 1/3, 1/32 and even 1/1024 Cherokee or Creek, for example), as if it were possible for this to be an accurate measurement of ethnicity.

A common question now faced by an Indian person who is of mixed race is: "How much Indian blood are you?" It is curious why such a question is not automatically asked of the Irish, German, Italian, or Polish Americans, or indeed of any other ethnic group in this country.

Only black ethnicity was measured at one time by "blood" in Louisiana (it was measured in quadroons and octoroons, etc.), presumably to insure that no one with any black ancestry would taint the white bloodline of the inhabitants. Any at-

tempt to resurrect this nonsense with blacks today would be met, I am sure, with extreme reactions.

Why then do such certificates continue to exist for American Indians and Alaskan Natives? Where else does such a system exist? And what cultural assumptions and scientific facts underly their persistent use?

Our ethnic identity includes our communities, histories, memories, traditions, rituals, and kinship, which cannot be found in a blood quantum.

have had no immunity, have cost the lives of millions. A recent study of the history of epidemics among American Indians and Alaskan Natives estimates that approximately 500,000 North American aborigines lost their lives each century from 1492 until 1900, the aboriginal population nadir.<sup>6</sup>

We as Native people have come close to extinction as a human community, and we are very conscious of that fact. Try to imagine a world without the benefit of the richness of our cultures, our experiences, and our presence. We have greatly contributed to the survival and growth of the American people, our country, and as far as that goes, the world. To illustrate what I mean: several years ago, I visited Romania, where I was presented with a meal of the Romanian national dish, *mamaliga*, a corn mush. It never occurred to my hosts that domesticated corn was a gift from aboriginal America to the Europeans. When most people think of potatoes, a staple in the European diet, they think of the Irish, even though potatoes were brought to the Irish from aboriginal America. My tribe, the Choctaw, even donated to the Irish Relief during the potato famine.

During the 20th Century, the Indian population grew substantially, from 100,000 to more than 1.5-1.7 million self-identified people of aboriginal descent, and to somewhat less than 900,000 legally-recognized tribal citizens. Nonetheless, Native Americans still make up less than 1% of the total U.S. population.

#### *Not All Indians Reside On Reservations*

When most people think of Native Americans, "reservation" is usually one of the first words that pops into their minds. In fact, only one out of four Native Americans resides on a reservation.<sup>7</sup>

Many Americans are unaware, for example, that what is now the state of Oklahoma was, prior to 1890, Indian Territory (not a true territory in the sense that Puerto Rico is a territory, but the location of small Indian republics). This territory was used, from the time of the purchase of Louisiana from France until the 1870s, as a relocation center for tribes driven from their homes in every region of the United States. The territory was originally granted by the U.S. to the so-called Five Civilized Tribes of the Southeast, with legal titles issued by the President of the U.S. After the Civil War, the Western lands of these tribes were taken and used for concentrating other tribes driven from their homes by the U.S. Army. Although the tribes of the Southeast had been forced to exchange their ancient homes for new land beyond the Mississippi, it came as a shock that, within one generation, the U.S. even took that away when in 1907 the state of Oklahoma was created. It may be of interest to note that, in 1906, the Five Civilized Tribes came within one vote in Congress of creating a separate Indian state called Sequoyah.

Oklahoma now has the second largest Indian population of any state. It, like California, the state with the largest population of Indians, is not a reservation state. In California, nine out of ten Native Americans live in urban areas;<sup>8</sup> there are only two sizeable reservations

and a number of tiny rancherias. Also, the bulk of the state's Indian population has come from other states.

Reservations, which can be found from Maine to Alaska, are an important fact of Indian life and are unique to us — a few, in fact, are larger than some states (for example, the Navajo, which covers territory in four states) — but they tell only part of our story.

The myth that Indians live only on reservations contributes to the lack of visibility of the majority of Indians who live in cities or in nonreservation rural settings, and thus to problems with HIV seroprevalence data, AIDS case surveillance, and resource allocation.

#### **HIV/AIDS in Native American Communities**

As of January 1990, 159 diagnosed cases of AIDS among American Indians, Alaskan Natives, and Native Hawaiians had been reported and verified by the CDC.<sup>9</sup> The Indian Health Service (IHS) and the CDC have just begun to undertake a seroprevalence survey of Native Americans nationwide. The purpose of this study is specifically to determine the extent of HIV infection in both rural and urban American Indian/Alaskan Natives communities. Results from this study are expected sometime in 1990.

AIDS cases have been reported among Native Americans in every region of the country, among both men and women, and from almost every age category; only ages 5 to 12 are not represented in the reported cases of AIDS, although there is a recent unofficial and unconfirmed report of a nine year old who was infected through sexual abuse. In comparison with the number of AIDS cases among whites, blacks, and Hispanics, these numbers may seem quite low. However, it is important to note that there are other sources of seroprevalence data, namely the Military Recruit Study and the Sentinel Hospital Study, that show American Indians/Alaskan Natives with higher rates of seropositivity than what one would expect from the number of reported cases.<sup>10</sup> In California, the seropositivity rate for American Indians/Alaskan Natives in the Military Recruit Study is 4.4/1,000 second only to, and almost tied with, blacks.<sup>11</sup> Compared to whites, relatively fewer men were infected through homosexual sexual behaviors, and relatively more were infected through IV drug use (though a portion of the IV drug users were also men who have had sexual intercourse with men).<sup>12</sup>

Because of misperceptions among non-Native Americans, efforts to inform Native American communities about the risk of HIV/AIDS, and how to prevent the virus from spreading, were relatively late in getting off the ground. Indian people were forced to take matters into their own hands when it became apparent that the government, health professionals, and AIDS activists of all kinds did not consider Native Americans at risk — or even consider them at all. Unfortunately, it was initially difficult for otherwise responsible people to believe that Indian people could be endangered by AIDS, in spite of acknowledged high rates of syphilis, gonorrhea, chlamydia, and substance abuse among our people.

Because of stereotyping, Native American people have not been acknowledged as being sexual in the

same way as the rest of humanity. For example, the suggestion that there were Indian people with same-gender or bisexual orientation was considered shocking. However, in the past three years, at least two major books have been published on traditional and contemporary bisexuality and homosexuality among American Indians.<sup>13, 14</sup> The books provide convincing evidence that many tribes have included a traditional social role for homosexual men; little has been written about women who are homosexual, which may be due to the fact that writers on the subject have been European men. Although many of our traditional attitudes have changed under the influence of Christian missionaries and general European culture, they have not entirely disappeared. As Lame Deer put it, "To us a man is what nature, or his dreams, makes him. We accept him for what he wants to be. That's up to him..."<sup>15</sup>

To a somewhat lesser extent, the same attitude and response has marked reactions to the use of IV drugs. Although most people associate alcohol abuse with Indian people — and there is a modicum of research on the subject — little has been known or written about Native Americans and the use of IV drugs, such as methamphetamines ("poor man's cocaine"), cocaine, and heroin, for example. Moreover, intravenous drug use is generally associated with cities (where Indians are not Indians according to some government officials) and is not considered an issue for the more isolated, rural Indian people. The reaction of some health professionals working with Indians has simply been to assume that IV drug use does not happen, rather than to thoroughly investigate the issue. The evidence that does exist points to a problem — at least in some communities.<sup>16</sup>

#### Indian Health Status and the Role of the Federal Government

A common misperception is that the federal Indian Health Service (IHS) takes care of the health needs of Indian people, and that Indian people receive generous benefits from the U.S. government. Attention to the need for HIV prevention education for Native Americans was delayed among states and other federal bureaucracies, partially because of the mistaken perception that the Indian Health Service would "take care of them."

The IHS is a poorly funded, small agency in a huge health bureaucracy that is unable to provide medical services for even one-half of the Indian population. For the past several years, the IHS has attempted to restrict its services to an even smaller proportion of the Indian population, but has not been successful. For example, three years ago the IHS published proposed regulations in the *Federal Register* to limit its services only to Indian individuals with one-quarter blood quantum or more of a particular tribe. Although the proposed regulations did not go into effect — due to the virtually unanimous Indian opposition and the intervention of Congress — the search for ways to serve only a few Indian people has continued. In spite of the fact that the majority of Indian people live in urban areas, urban Indian health programs have faced over the past several years an ongoing effort by the Executive Branch of the government to

## RESOURCES DESIGNED FOR NATIVE AMERICAN COMMUNITIES

**WE OWE IT TO OURSELVES AND TO OUR CHILDREN**, an awardwinning health education publication designed especially for Native American communities, is a booklet of traditional poetry, Native American stories, and images. Focus group testing showed that Native Americans felt embarrassed by most materials on STDs. To diffuse the embarrassment associated with STDs, this book was designed to be subtle, beautiful, and informative, in order to effectively teach individuals in small group settings about sexually transmitted disease (STD) prevention and treatment, including condom use.

*Grandmother Spider  
Wove the world out of Herself  
Silvery strands of color  
connecting all  
weaving webs of generations  
and regenerations*

(This excerpt from the book is accompanied by a photograph speaking of the strength of a Yuma mother, holding a child on her lap.)

The images and legends appeal to individuals to think not only of themselves, but of the family, and of the generations to follow. They reflect the Native American tradition of being connected to the group, the tribe, and the family, and also reflect the reality that STDs are not an individual problem, but one of relationships and of society. The publication demonstrates that it is possible to present a number of messages, combine traditional Native American approaches with government health guidelines, and still speak to the reader with sensitivity and respect. \$5.

**WE OWE IT TO OURSELVES AND TO OUR CHILDREN: THE VIDEO** uses cartoons from *Understanding STDs* and *Understanding AIDS and HIV* to illustrate the causes, symptoms, treatment, and prevention of AIDS and STDs. 8 mins. \$35.

**UNDERSTANDING STDs** is a *storytelling packet* that consists of 25 separate cartoons illustrating the treatment and prevention of STDs. Each 8½x11 cartoon comes with text. Includes a facilitator's guide, with instructions for making handouts, transparencies, and slides for group presentations. \$5.

take away their funding support.

Even the medical care available to the few eligible Indian people has been severely restricted. An example of this is the fact that in 1984 per capita annual expenditures for contract care (the care mainly provided by sec-

**UNDERSTANDING AIDS AND HIV**, a companion piece to *Understanding STDs*, is a *storytelling packet* that consists of 25 separate cartoons illustrating the treatment and prevention of HIV infection and AIDS. Each 8½x11 cartoon comes with text. Includes a facilitator's guide with instructions for making handouts, transparencies, and slides for group presentations. \$5.

**CIRCLE OF WARRIORS**, a video (produced by the Alaska Native Health Board, in conjunction with the Seattle Indian Health Board and NNAAPC, and dedicated to the memory of Ray Harjo) featuring nine Native American adults and one child who are living with HIV/AIDS. They discuss sexuality, health, discrimination, and family. 27 mins. \$75.

**FACE TO FACE**, a video (produced by the Alaska Native Health Board, in conjunction with the Seattle Indian Health Board and NNAAPC, and dedicated to the memory of Ray Harjo) is composed of five extended interviews with Native Americans living AIDS who discuss various aspects of their lives, including health, sexuality, testing, childrearing, and discrimination. Discussion guide included. 47 mins. \$100.

**AIDS: THE BASICS. A MANUAL FOR NATIVE AMERICAN HEALTH AND HUMAN SERVICE WORKERS** — developed by Ron Rowell, MPH (Choctaw/Kaskaskia), Terry Tafoya, PhD (Taos Pueblo/Warm Springs), and Corinne Axelrod, MPH, (California Rural Indian Health Board) — covers: AIDS and substance abuse, STDs, attitudes, beliefs and psychosocial issues, traditional Native American medicine and AIDS, training, and target groups. Includes a sample needs assessment, a lesson guide, sample pre- and posttests, and other methods of evaluation, references, statistics, and a glossary. \$5.

**SEASONS**, a quarterly publication of NNAAPC, contains information about AIDS and HIV infection, HIV prevention, models for education, and updates on treatments, grants, and training. Free.

**INDIAN AIDS HOTLINE: 800/283-AIDS**

For more information contact the National Native American AIDS Prevention Center, 6239 College Avenue, Suite 201, Oakland, CA 94618, 415/658-2051.

ondary and tertiary care centers outside of IHS, but paid for by IHS) ranged from \$7.33 in California to \$473.15 in Montana and Wyoming.<sup>17</sup> If you live, as I do, in an area where it is difficult to buy even one lunch or dinner for \$7.33, or if you are familiar with the cost of a one-day

stay in an average hospital, you will understand the quantity and quality of the health care that these funds purchase. When IHS has no funds to purchase AZT or aerosol pentamidine, for example, Indians with HIV infection may go without life-enhancing treatments. Physicians and health activists are now discussing the concept of "rationed care" for the general population, but for American Indians such care has been a way of life for decades.

A few years ago, the IHS budget was slashed by several million and the funds were transferred to the National Institutes of Health under pressure for increased government funding for AIDS. That money was never replaced, nor were the funds used to establish HIV prevention programs in American Indian communities.

*"...the health status of Indian people is still poorer than that of the general U.S. population, on almost every health indicator."*

In a system in which public funds are allocated on the basis of clout, either in numbers or due to a high degree of political organization, American Indians have had neither. Moreover, there has been little public support for continuing to provide Native Americans with the services promised in the past, and virtually no understanding that the minimal services that are provided were bought at a very high price. If one combines the lack of understanding among most Americans of the contracts their ancestors originally made with the native peoples of this land, along with the small Native American population, any attempt to improve the health of our people or to guarantee our rights under solemn agreements becomes extremely difficult, in almost all circumstances.

It should therefore not be surprising that the health status of Indian people is still poorer than that of the general U.S. population on almost every health indicator.<sup>18</sup> Thirty-seven percent of Native American people die before the age of 45. In 1985, of the top 10 causes of mortality, four were directly caused by substance abuse, and the majority, if not all the rest, can be viewed as indirectly related. Infant mortality rates among Native Americans have improved considerably since the mid-1950s, but these rates still exceed those of all other races in the U.S., largely due to death in post-neonates.<sup>19</sup>

#### **Outreach in Native American Communities**

Although we might wish that AIDS education outreach efforts had been begun earlier, having been forced to organize our own efforts has not been without its benefits. This new challenge has reminded us of the elements of our culture that have allowed us to survive, in spite of everything that has happened, and to apply what we have learned in working with the AIDS epidemic. For example, our cultures' common values — respect for our elders, teaching our children survival skills, focusing on the extended family, strong spiritual traditions, storytelling and humor — all have helped us to

## **Traditional Medicine People Gather To Talk About AIDS**

A special "Gathering for Traditional Medicine People and Healers to Talk About AIDS," is now sponsored annually in California by the Native American AIDS Advisory Board. Close to 200 people attended the last gathering, representing more than 33 tribes from throughout the state, to obtain information about AIDS, to discuss HIV/AIDS among Indian people, and to learn how traditional Native American practices, including the use of medicines and herbs, can be effectively used to help prevent and treat HIV/AIDS and other health problems, such as alcohol and drug abuse, in Native American communities. The three-day event has included traditional Native American ceremonies, sweats, and dancing.

Further information on these gatherings can be obtained by contacting Larry Murillo, Project Director, Native American AIDS Education and Prevention Program, California Rural Indian Health Board, 2020 Hurley Way, Suite 155, Sacramento, CA 95825, 916/929-9761.

design educational strategies that work for our communities. Traditional Native American healers have been quick to respond to the epidemic and traditional healing practices, many of which are preventive in nature, are being used. Indian people with AIDS have chosen to involve both traditional and Western medicine in their treatment plans. Also, Indian artists and musicians have worked on the design of materials. The AIDS prevention effort has become a force in the broader movement of self-determination for Native American people.

Indian communities have come together, and they have begun to organize. There are now locally-based, regional and national Indian AIDS prevention education efforts, both funded and unfunded.

The National Native American AIDS Prevention Center (NNAAPC) in Oakland, California was funded by the U.S. Centers for Disease Control in 1988 to assist locally-based and regional efforts with training and technical assistance. NNAAPC is an Indian governed and managed private nonprofit organization. The agency operates a national toll-free Indian AIDS Hotline and a clearinghouse for Native American-targeted, AIDS-related, health education materials, and provides information services to clients, including distribution of a quarterly newsletter, *Seasons*. The National Indian AIDS Media Consortium, also funded by the CDC, is a NNAAPC cooperative project with the Native American Press Association that provides ongoing information to Indian newspapers and radio and television stations about HIV/AIDS, in order to encourage regular reporting on the issue.

Another national organization, the American Indian Health Care Association of St. Paul, Minnesota is also funded by the Centers for Disease Control to produce Native American-targeted health education materials and to assist its urban Indian clinic members.

In some states, Washington, for example, the Seattle Indian Health Board has joined forces with other people of color to insure that resources are made available for Native American projects. In Minnesota, the Minnesota American Indian AIDS Task Force has done an outstanding job of organizing both urban and reservation communities, and is working cooperatively with a wide range of agen-

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cies and organizations. The Alaska Native Health Board has worked long and hard to reach isolated communities by utilizing new communications technologies and by producing excellent educational materials. In Arizona, the Inter-Tribal Council of Arizona has organized reservation-based AIDS prevention activities. In Phoenix, the urban Indian clinic has begun an outreach program to gay and bisexual Indian men and is working closely with

the Arizona Department of Health. In California, San Francisco's American Indian AIDS Institute has developed AIDS educational materials for Indian men and for teens and has provided training to local Indian agencies, and the Native American Health Board of Oakland has begun a Youth Empowerment Project to train Indian teens as peer counselors. In Oklahoma, the Intertribal AIDS Task Force and Oklahoma City's urban Indian clinic have been working hard to get the word out and to support Indian people with AIDS. In South Dakota, the Native American Women's Health Education Resource Center has begun organizing a statewide Indian AIDS Task Force, with participation from most of the reservations in that state. In Maine, the Penobscots and Passamaquoddies have established community-wide AIDS task forces and have held town hall meetings.

This is by no means an exhaustive list of AIDS activities in Indian country, but as you can see, Indian people have responded vigorously to the challenge posed by AIDS. *We know an enemy when we see one.*

### Conclusion

Most Indians realize that AIDS cannot be divorced from other major health problems. They are all connected, and we must enable others to see these connections. There are many ways to approach HIV/AIDS prevention, but STD control and substance abuse prevention and intervention are the most obvious. The purpose of HIV/AIDS prevention education is to change behaviors that place individuals at risk. If we succeed in changing the sexual and substance abusing behaviors at the root of HIV transmission, we will also succeed in preventing other major problems like Fetal Alcohol Syndrome, STDs, chronic liver disease, and the majority of accidents, homicides, and suicides that occur among Native Americans. We must use every avenue open to us.

Our struggle is — as it has been for so long — a struggle for survival as a people. We are not being alarmist when we raise the potential of another demographic collapse due to HIV/AIDS and the disappearance of entire indigenous cultures. An epidemic which primarily affects individuals in their most fecund years can destroy a tribe's future. It has happened before in our history and it can happen again. However, we are tough and we are determined. We will survive the AIDS challenge. We have 30,000 years of experience in America to help us do so.

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# HIV/AIDS AND THE ASIAN AND PACIFIC ISLANDER COMMUNITY

**Deborah A. Lee, MA**

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**Kevin Fong**

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**“W**e are sitting on a time bomb that is wired to cultural and medical issues that are being ignored and neglected. The disease has also spotlighted inadequate health care services for the poor, as AIDS becomes less a terminal illness, and more a chronic disease. If the disease doesn't kill us, the continued lack of medical services surely will.”

— Dr. Bertie Mo, medical anthropologist and AIDS educator<sup>1</sup>

The year 1990 marks a new decade, with a renewed emphasis on a *multicultural approach* to AIDS education outreach efforts and services for the ethnic populations of the United States, including the Asian and Pacific Islander communities. The need for multilingual/multicultural services for these communities has become imperative, while funding for serving this growing population unfortunately has dwindled, seriously affecting an already inadequate health care system.

## Some Background Information on This Population

Asians and Pacific Islanders are expected to account for about 15% of the nation's total population growth between 1990 and 2000 (they accounted for 12% between 1980 and 1990), and 18% between 2000 and 2010.<sup>2</sup> In essence, they are the nation's fastest growing minority group measured in percentage growth. Between 1970 and 1980, the Asian and Pacific Islander population increased from 1.5 million to more than 3.7 million, a 141% increase as compared to a 11% increase for the general U.S. population.<sup>3</sup> This tremendous rate of growth continued into the eighties, with estimates by the Population Reference Bureau of an increase of 1.6 million between 1980 and 1985, which brought the total Asian and Pacific Islander population to 5.2 million in 1985.<sup>4</sup> This increase can be attributed, in part, to changes in immigration laws during the mid-1960s, which lifted restrictions to immigration (Filipinos, Japa-

nese, Koreans, Asian Indians) and, since 1975, to the admission of Southeast Asian refugees (Vietnamese, Cambodians, Laotians, and other ethnic subgroups).

During the last eight years, more than 800,000 Southeast Asians have settled in the United States; the largest percentage reside in California, Hawaii, New York, Illinois, and Texas.<sup>6</sup> Of the total Asian Pacific Islander population, 1980 census figures indicate that 59% are foreign-born, and that 69% speak a language, other than English, at home.<sup>7</sup>

## Asians and Pacific Islanders are Culturally Diverse, Yet Similar

One must be sensitive to the “lumping” of Asians and Pacific Islanders together as one homogenous group. In addressing the health care/AIDS information and education needs of Asians and Pacific Islanders in the United States, it is necessary to recognize the cultural diversity of this population. There are at least 43 different Asian and Pacific Islander groups (see box on page 17), from more than 40 countries and territories, who speak more than 100 different languages and dialects (some unwritten). Each group has a distinct culture and heritage.

Recognizing and understanding the distinctions among the different groups are especially important when attempting to address their needs, and to reach them with appropriate information and education programs. For example, nearly 90% of Filipino Americans are Catholic and come from a country where the institutions are modeled after those of the U.S., but most Vietnamese are Buddhist and, until the last few decades, came from a tradition of a monarchy government.

The nuances that occur within the individual communities must be seriously considered — American-born *vs* foreign-born, gay *vs* straight, the traditional roles of parents and children, female and male issues, the internal class structures, and the “generation gaps” (new immigrants and refugees, and old; age differences) — to name just a few.

One must also understand that there are, as well, certain basic similarities that pervade all Asian and Pacific Islander cultures. *First*, the family and community are a

# Asians and Pacific Islanders As Listed By the U.S. Census Bureau

## Asian Groups

Chinese  
Filipino  
Japanese  
Asian Indian  
Korean  
Vietnamese  
Bangladeshi  
Burmese  
Cambodian  
Hmong  
Indonesian  
Loatian  
Malayan  
Sikkimese

Okinawan  
Pakistani  
Sri Lankan  
Thai  
Bhutanese  
Borneo  
Celebesian  
Cernan  
Indochinese  
Iwo Jiman  
Javanese  
Maldivian  
Nepali  
Singaporean

## Pacific Islander Groups

### Polynesian

Hawaiian  
Samoan  
Tahitian  
Tongan  
Tokelauan

### Micronesian

Guamanian  
Saipanese  
Tinian Islander  
Mariana Islander  
Marshallese  
Palauan

### Melanesian

Fiji  
Papua New Guinean  
Solomon Islander  
New Hebrides Islander

ers have enormous problems with discussing sexual behaviors — despite the threat that HIV/AIDS represents to their lives — and, particularly, in the detail required for understanding the transmission of HIV. They tend to believe that if members of their communities adhere to traditional cultural norms and do not engage in sexual behaviors, or marry, outside of the community, they will not be at high-risk, and there will be no need to be concerned about HIV/AIDS — “Do not fool around with the ‘white devils!’” they caution.

## The “Model Minority” Myth

Some say that, while Asians and Pacific Islanders are often high achievers, the “model minority” myth — which is perpetuated by the media — that *they* are *always* academic and economic achievers, and are successful, compliant, quiet, and appropriately subservient — obscures serious problems in these communities, including poverty, substance abuse, mental illness, and domestic violence. The “model minority” label also puts Asians and Pacific Islanders in an uncomfortable comparative position. Other minorities, in effect, are told: “Why can’t you be more like Asians and Pacific Islanders? Just work hard, keep quiet, and stop asking for handouts.” Thus, they are targets for resentment, while the government and businesses play down the obstacles that hinder the progress of other minority groups. Lastly, the seeming superiority of this “model minority” alarms some Americans, who feel that Asians and Pacific Islanders are “taking over.” Because they are not regarded as “real Americans,” they are seen as a threat, rather than as an asset, in American society.

The median income for Asian and Pacific Islander families is slightly higher than the national average, but the statistics are skewed by the existence of a number of Asian Pacific people in the higher socioeconomic groups, which distorts the actual situation of this community.<sup>8</sup> Contrary to popular belief, a large number of Asians and Pacific Islanders — most often immigrants or refugees — live below the poverty level (they have an average poverty rate of 13% as compared to the national poverty rate of 12%), speak limited English, are limited to accessible and affordable health care, and suffer from numerous health problems. This bipolar or bimodal distribution of Asians and Pacific Islanders is frequently overlooked when studying this community, which reinforces the view that they have few, if any, problems of any kind.

The model minority myth also portrays Asians and Pacific Islanders as having excellent health, as does existing medical literature and government data, which reinforces the belief by policymakers, planners, and funders that there are no significant health problems within this population.

But, the studies that such conclusions are based on have serious shortcomings and are severely lacking in conclusive evidence. The main problem with the data is that crucial distinctions are not made between the various ethnic and socioeconomic subgroups within the overall population; the health care needs of one subgroup do not necessarily apply to the others. In addition, differences between recently arrivals and United States-

vital part of each individual’s lifestyle, to the point that the needs of the family almost always supercede the needs of the individual. *Secondly*, sexual discussions are virtually taboo within these cultures. *Thirdly*, homosexuality is not accepted, either within the families or within the communities, which are considered one and the same among these groups. And *lastly*, any discussion of illness and death, in many of these cultures, is seen as a self-fulfilling prophecy; therefore such discussion is generally forbidden.

AIDS, unfortunately, integrates all of these factors, which makes any discussion concerning the disease difficult and complex. Moreover, Asians and Pacific Island-

born Asians and Pacific Islanders are typically overlooked, yet such differences are extremely important when attempting to reach these groups with information and services. Current data is weighted against the longer, more established, healthier, ethnic groups, rather than the less settled, immigrant and refugee groups.<sup>10</sup> The studies also frequently make conclusions about Asians and Pacific Islanders using an insufficient sample size, and offer limited data on mortality and other health status indicators.

The lack of available data helps to perpetuate the model minority myth, and generalized interpretations of current data poses a problem in identifying the real health needs of Asians and Pacific Islanders. This leads decision-makers to conclude that there is no need for social services, affirmative action programs, and other necessary supports. It is important that this situation be addressed. Diminished funding for important and necessary health programs, vital to the health status and care of the Asian and Pacific Islander population, including people with AIDS, will otherwise mean the elimination of absolutely crucial services.

#### **Denial — “Asians and Pacific Islanders Do Not Get AIDS”**

*“Suffering in silence is one of the great tragedies of the Asian culture.”*

— Amy Tan, author of *The Joy Luck Club*<sup>11</sup>

The fact that Asians and Pacific Islanders are viewed as a “model minority” lends itself to misconceptions that tend to perpetuate stereotypes, not only by the greater society, but even among Asians and Pacific Islanders themselves. *Even they see themselves as the model minority—the achievers who do not engage in high-risk sexual behaviors or shoot drugs.*

To a great extent, the Chinese, Japanese, Koreans, Southeast Asians, and Filipinos all reflect similar cultural attitudes towards sexuality. Sexuality is not considered an appropriate topic for discussion, and by some religious (Catholic) and institutional (Confucian) norms, such discussion is even considered immoral. It is, therefore, easy to understand that most heterosexual Asians and Pacific Islanders do not believe that members of their communities engage in high-risk sexual behaviors or use drugs.

The youth in these cultures are expected to be obedient and filial. They feel pressure, because of traditional customs, to please their parents by excelling in school, for example, or by becoming betrothed in their early teens. In some of these cultures, once the females start menstruating, they are expected to procreate (possibly a child every two years) and carry on the family name. Many of them succumb to the pressures of living in a bicultural society and turn to drugs and alcohol.

There is even greater reluctance to believe that a significant gay and lesbian population exists within their communities. Homosexuality, despite its existence in all Asian and Pacific Islander countries, is suppressed — most homosexuals are “in the closet.” Moreover, fami-

lies with homosexual members are often stigmatized. Familial, economic, and cultural ties to the community and family lead gay Asians and Pacific Islanders (especially immigrants who find it difficult to assimilate into the white, gay subculture) to have sexual contacts with those of other ethnic groups and to have more anonymous contacts. Also, many men fulfill their familial obligation of marriage and children, but continue to engage in homosexual behaviors; bisexual men are especially hard to reach because of their low visibility; and members of these communities are generally ignorant in regard to safer sex practices.

Because of denial, misperceptions, and inaccurate information, many heterosexuals have continued to deny the existence of AIDS in their communities, believing that if individuals in their communities adhere to cultural norms, there will be no need to be concerned about AIDS. AIDS, perceived as a “gay, white” disease, is looked upon with intense homophobia. The prevailing attitude, that if Asians and Pacific Islanders stick with their own, they will not get AIDS, reinforces the overall community’s continuing reluctance to accept the AIDS epidemic as a problem, which is a great barrier in providing adequate services to the HIV-infected. This denial is especially evident when working with people with AIDS, as will be seen in the examples that follow. It is also important to understand that terminal illnesses such as cancer are taboo topics of discussion. Because of traditional beliefs about “fate,” such illnesses, which now include AIDS, may cause shame within a family. Responsibility for contracting such diseases is frequently placed on the family, by themselves and by others — the disease is the result of bad spirits, karma, “I did something to offend my ancestors,” for instance.

Many Asian and Pacific Islanders with HIV/AIDS hide their illness until the last stages of the disease, or even worse, they suffer and die in isolation. The following examples may help to clarify the importance of family and of not disgracing the family, duty, filial piety, fear and ignorance, shame, and saving face in these cultures — concerns not generally perceived nor understood by mainstream AIDS agencies.

*A Vietnamese immigrant, a gay man in his 30s who lives with his mother and sister, visits an AIDS health care agency. Primarily monolingual, he refuses the services of a translator — another gay man — because he fears that he might know the person. Sacrificing his own health, he protects his secret from his family and his community.<sup>12</sup>*

*A 24-year-old Japanese student mysteriously left Los Angeles two months after he had bought a condominium. Friends said he returned to Japan because he found out that he had AIDS. His family claimed he died two years later of a heart attack.<sup>13</sup>*

*A gay Hawaiian man with AIDS is admitted to the hospital with pneumocystis for the third time. When he calls his mother to inform her of his situation, she hangs up.<sup>14</sup>*

*A San Francisco AIDS/ARC hospice approves an Asian contractor's bid to renovate the outside of their building. Before any work is done, the contractor refuses the job saying his crew is at-risk because there are people with AIDS inside. Despite attempts by the Human Rights commission to educate the contractor and his employees in their native language, they respond by burning their "contaminated" clothes and educational materials.<sup>15</sup>*

*A Cambodian woman with AIDS is ostracized by the close-knit community in which she socialized. The people in her community believe that AIDS is easily transmitted. After she dies, her husband and five children are exiled from their community.<sup>16</sup>*

#### **Reported AIDS Cases**

In early 1983, one of the first public AIDS conferences was held in San Francisco at the University of California Medical Center. An epidemiologist stated to the 100 people in the audience that Asians were believed immune to the deadly virus.<sup>17</sup> There were no reported cases of AIDS for either Asian men or men of Italian ethnicity at that time. The medical community looked upon this with hope, as studying a group that

appeared to be immune might give important clues concerning the nature of the disease itself, about which very little was known. In the early stages of the disease, 1982-84, personal ads soliciting Asian men for relationships substantially increased.<sup>18</sup> Some concluded that this happened because white men assumed that they would be safe from the disease if they had Asian partners. Myths, stereotypes, and misinformation, such as the belief that Asian men were immune and lived clean lifestyles — free of drug and alcohol abuse — may have led to social/sexual partnering that possibly helped spread AIDS from the mainstream gay community to Asian gays. Asian men, as well, may have endangered themselves by being misled by the popular opinion that they could not be affected by the virus.

The hypothesis that Asians and Pacific Islanders were immune, unfortunately, was sadly disproved as the first case of AIDS in an Asian person was diagnosed three weeks later in California.<sup>19</sup> Between 1983 and 1987, statistics were kept only for whites, blacks, Hispanics, and "others" (Asians and Pacific Islanders, Native Americans, etc. were all lumped together under this category), so there was no national record of Asian and Pacific Islander AIDS cases until 1988, when the government finally created the "Asian/Pacific Islander" category — the result of nationwide advocacy efforts by many different groups.<sup>20</sup> Asians/Pacific Islanders and Native Americans

## **BEHIND THE MASK... AIDS: IT AFFECTS ALL OF US**

**A Review by Carolyn Patierno, SIECUS AIDS Associate**

The Asian and Pacific Islander community, which is the focus of the videotape *Behind the Mask...AIDS: It Affects All of Us*, tends to evoke images of mystery, of the exotic, and of serene simplicity. The mask of silence therefore prevails. The AIDS crisis, a crisis of great difficulty and devastation, does not lend itself to open discussion within Asian and Pacific communities; however, open discussion is precisely what is needed.

The powerful feature of this video, then, is that it profiles Asian-Pacific people with AIDS (PWAs), and their families, and reveals the harsh reality of living with AIDS within their communities. Those profiled in the video share their experiences and their pain, encouraging viewers to protect themselves and those they love. The most effective means of protection — communication — is encouraged throughout the video. One PWA explains that Asian-Pacific Islanders are taught not to show their emotions. (Not unlike many other cultures). However, she says, "education is the key," and in order to educate and be educated, people must communicate.

The family of a man who has died of AIDS-related illnesses is profiled; each is supportive and shows great love for the man, who is their son, brother, and uncle. Dealing with AIDS as a family, they rally around him. One nephew says, "We had him until the following June" (one year after he had been diagnosed). The same young man, in-

spired by his family's experience, goes on to say that people "have to think about what to do to protect themselves or to help other people who have AIDS."

Another PWA, a woman, emphatically states that "there is no shame in finding out how to protect ourselves and our families." Despite her diagnosis, she remains positive in her attitude regarding sexuality: "Sex, like anything else, is there to be enjoyed." However, she adds, protection is of utmost importance.

The video covers the epidemiology of the virus and avenues of transmission — and the information is accurate. Also acknowledged are medications that are Eastern in their origins. It is during these segments that the video tends to be clinical. A bit of a chasm is created between the more personal accounts of HIV/AIDS and the more clinical sections. Nonetheless, the video is professionally and sensitively produced, and the message is clearly stated over and over again: AIDS is everyone's problem. It affects all communities. So, it is up to all of us to try to bring its devastation to a halt.

*Association of Asian/Pacific Community Health Organizations, 310 8th Street, Suite 310, Oakland, CA 94607, 415/272-9536. Price per videotape: \$50, nonprofit \$35; set of 1/2" videotapes in six languages (English, Cantonese, Korean, Samoan, Tagalog and Vietnamese): \$250, nonprofit \$175. Free audiocassette available.*

now are separate subgroups. However, in looking at local statistics, in San Francisco alone the Asian and Pacific Islander community experienced a 77% jump in cases between 1987 and 1988.<sup>21</sup>

As of January 1990, the total number of Asian and Pacific Islander AIDS cases reported to the Centers for Disease Control was 757. Seventy-five percent of all adult cases of AIDS in this community have been attributed to male homosexual/bisexual contact, 4% to IV drug use, 2% to coagulation disorders; and 8% to blood transfusions (received before 1985). Fourteen percent of AIDS cases occur in persons over age 50, a higher rate than found among, whites, blacks, Hispanics, or Native Americans. One percent of males, and 35% of females, contracted HIV through heterosexual contact, which is higher than the rate found among white, black, Hispanic, or Native American women. Nine cases of pediatric AIDS have been reported: three are children with hemophilia; three have mothers who tested positive for HIV; and three contracted the virus through blood transfusions.<sup>22</sup>

National statistics are not available by ethnic subgroups, however, which is a major issue among the educators and researchers of this community. When statistics were gathered for the subgroups in San Francisco, however, the Filipino community was found to have been most affected by HIV/AIDS, accounting for nearly 46% of Asian and Pacific Islander AIDS cases. They were followed by the Japanese, 19%; the Chinese, 20%; the Polynesian/Hawaiian, 7%; and the Vietnamese, 4%.<sup>23</sup>

The above figure of total AIDS cases (757) must be considered neither complete nor absolutely reliable as an indicator of AIDS cases within the Asian and Pacific Islander community for a number of reasons. Most importantly, of course, is the fact that statistics were not kept for Asians as a separate ethnic group until one year ago.

Moreover, there has been widespread underreporting. One instance of this is illustrated by the following: at a recent HIV/AIDS support group in Los Angeles, only nine of the 16 individuals claimed that their cases were recorded by the CDC as "Asian/Pacific Islander"; two were of mixed heritage, but were reported as "white"; and the remaining five, to their knowledge, were not reported at all.<sup>24</sup>

But, there are other reasons as well. If the person with AIDS is an immigrant, s/he may return to his or her birth country before the case is reported in the United States. Or s/he might stay in this country, but fail to seek treatment because of the stigma of homosexuality and drug use attached to the disease. In addition, some traditional Asian and Pacific Islander doctors do not feel that reporting is of great importance, and therefore do not report their patients' cases.

Many individuals also mask their illness as cancer, leukemia, or other illnesses, to avoid possible deportation by immigration officials. Restrictive immigration and naturalization laws and regulations inhibit newcomers from seeking health care. If an applicant seeking permanent residency applies for welfare or Medicaid assistance, information will be documented that could possibly be used to deny the applicant citizenship or lead to deportation. Due to these implications, many immigrants will not seek Medicaid assistance or the services of health centers.

Mandatory HIV testing of immigrants and refugees creates further problems. The implications are clear that HIV-positive persons will be denied legal immigration status. Charges that the Immigration and Naturalization Service's (INS) mandatory HIV-testing program is discriminatory and inadequate are not surprising. Critics have claimed that its sole purpose is to deny legal status to HIV-positive persons and that it will lead those who are found to be HIV-positive to deportation to their native countries, most of which do not have adequate resources or treatment facilities available for treating HIV-infected people.

*An immigrant from Thailand recently returned to his home country for a visit. While he was there, it was discovered that he was HIV-positive. INS will not allow him to return to the United States to be with his wife and child. He is presently living in a refugee camp.<sup>25</sup>*

With these factors in mind, we are led to believe that the actual number of AIDS cases among Asians and Pacific Islanders is much higher than it appears. And, although the absolute rate of AIDS cases in this community is relatively low, it is important to note, that in comparing the monthly HIV/AIDS surveillance reports from January 1989 to January 1990, there was a 32% increase in the number of AIDS cases among these groups within only one year's time.<sup>26</sup>

### **Informational and Educational Outreach and the Role of the Media**

It was not until 1987, four years after the first Asian/Pacific AIDS case was diagnosed in the U.S., that an agency was funded specifically for prevention and education within the Asian and Pacific Islander communities. Currently, there are several agencies providing prevention and education workshops and materials in different Asian and Pacific Islander languages. However, most of these agencies are located on the West Coast, specifically San Francisco, Oakland, Seattle, Los Angeles, and Honolulu. Services for Asians and Pacific Islanders in other parts of the U.S., particularly New York, Boston, Washington DC, and Chicago, are severely lacking. Culturally appropriate direct services for HIV-infected Asians and Pacific Islanders are virtually nonexistent. Because of the lack of available funds (efforts to obtain funds are a continual struggle), volunteer efforts and grassroots organizations continue to play an important role in outreach to the Asian and Pacific Islander communities.

National organizations, such as the Asian American Health Forum (AAHF), the Association of Asian/Pacific Community Health organizations (AAPCHO) and the National Asian/Pacific American Families Against Substance Abuse (NAPAFASA), are creating platforms to advocate

for increased funding and awareness in an effort to combat the epidemic within the Asian and Pacific Islander communities. Also, several coalitions have been formed by various agencies and individuals to address the lack of funding and available services.

Mainstream AIDS agencies also have had difficulty in confronting the challenge of reaching the Asian and Pacific Islander communities, and only recently have begun implementing programs to target these populations. Both the San Francisco AIDS Foundation and the AIDS Project of Los Angeles have been funded to develop an informational hotline in several Asian languages. In both cases, however, the funding for these projects are limited, and not expected to last for more than one year. While some mainstream AIDS organizations "do their best" to provide clinical and support services, language and cultural barriers impede these groups from providing proper and effective care. In addition, many Asians and Pacific Islanders do not have access to clinical trials and other programs (i.e. food banks and emergency funds) due to the aforementioned barriers.

Most public and private sector facilities — whether mainstream or Asian and Pacific Islander-serving agencies — that do provide primary, secondary, and tertiary care in a culturally-relevant manner are inadequate or nonexistent in these communities. The few centers that provide such services operate with limited resources and most often cannot meet the demand of patients seeking care. Furthermore, access to bilingual-bicultural health care workers is largely limited, and most often unavailable at most facilities that serve large numbers of Asians and Pacific Islanders. *The shortage of bilingual, culturally-sensitive services, unfortunately, is a determining factor in whether health care will be sought.*

Lack of proper financing; racism among mainstream agencies and funding organizations; issues in regard to sexuality and AIDS education, homophobia, and drug use; denial within the Asian and Pacific Islander communities; and cultural and language barriers all contribute to the continued lack of adequate and effective services for this rapidly growing population, and create barriers for those who are attempting to provide AIDS education and services to the Asian and Pacific Islander communities. Also, very little research has been done on Asian and Pacific Islander communities. A survey of AIDS knowledge and attitudes within the Chinese and Japanese communities in San Francisco was recently completed, and a similar survey within the Filipino community is currently underway. But, other proposed research projects have typically been rejected.

In a community where homophobia is extreme, and where 75% of AIDS cases are male homosexuals/bisexuals, proper methods of outreach and services have been unsuccessful, or even worse, they have been nonexistent. Mainstream gay safer sex models have been attempted by Asian and Pacific Islander health/AIDS educators, but they have failed in these communities. For example, in San Francisco, the "Stop AIDS" model, developed by gay men, was found to be ineffective among

gay Asian and Pacific Islander men, because it was not culturally relevant. Moreover, other models that have been developed by the gay community that work for the black and Latino communities have been ineffective among Asians and Pacific Islanders who are grappling with HIV/AIDS.

Dr. Terry Gock, chair of the Asian Pacific AIDS Task Force in Los Angeles, estimates that at least 50% of Asian and Pacific Islanders with AIDS are first generation.<sup>27</sup> First generation immigrants and refugees lack knowledge of Western medical practices (males, especially, show great pride when stating that they have never been to any "doctor," for example, and tend not to be prone to preventive health care measures). Other barriers, including their invisibility within the communities and language, trust, and confidentiality issues, lead to the total frustration of the health care providers and educators who are trying to reach them. Collaborative efforts among the gay/bisexual and heterosexual communities, however, are starting to pave the way for ongoing dialogues that address crucial issues such as these — and others, such as sexuality, drug and alcohol use, death, and outreach to women and youth.

For prevention and treatment methods to be effective within these highly diverse communities, they must be culturally sensitive and linguistically specific.

*A 61-year-old Southeast Asian woman with AIDS is admitted to the hospital, because she is not taking the correct doses of her medication. Her son misinterpreted the doctor's instructions because he did not understand English very well.<sup>28</sup>*

For example, there are no pamphlets targeted toward English-speaking Asians and Pacific Islanders, and many of the existing mainstream pamphlets that have been designed for the general population are not culturally appropriate.

Also, there are many obstacles encountered when attempting to develop presentations in the different languages. The Tagalog language, for instance, does not have clinical terms for words such as penis, vagina, or intercourse. Therefore, the community health worker has to use familiar street terms, which many people find offensive, or English terms, which many people do not understand.

Many concepts and behaviors do not translate easily into Asian and Pacific Islander languages. For example, the Chinese characters used to pronounce AIDS, literally translates as, "love, disease, death" — and, what does that mean? Mixed and conflicting messages are given by these characters. In many Asian languages, the literal translation for "homosexual" is "deviant."

Another obstacle in regard to language can be noted in the Mien and Hmong communities, which do not have written languages. How then does one effectively and efficiently administer a pre- and posttest? There are also high illiteracy rates among Asian and Pacific Islanders; almost 80% of Laotian and Cambodian Americans, for

instance, cannot read their own languages.

Mainstream media plays a powerful role in educating the general public, including English-speaking Asians and Pacific Islanders, who rely heavily upon such outlets as their main source for information. Nonetheless, nationwide campaigns on matters such as substance abuse, sexually transmitted diseases, and AIDS do not address or portray Asians or Pacific Islanders, and, when they do, they often perpetuate the model minority myth and stereotypes that tend to compound problems even further.

In addition, Asian language media has historically reported false information on HIV/AIDS. In early 1983, when information was revealed that Asians and Pacific Islanders may be immune to HIV, it was featured by the Asian language media. Now, seven years later, many of those who heard or read this information still believe they are immune to HIV. As recent as October 1989, a Filipino newspaper headline read, "The Phillipines' AIDS problem — Not Serious."<sup>29</sup> Conversely, the Filipino community has been the most affected of all Asian and Pacific Islanders. Such misreporting is particularly of concern to those conducting AIDS outreach programs in culturally diverse communities, as many Asian and Pacific Islander immigrants and refugees cannot benefit from mainstream media efforts because of their cultural differences and levels of acculturation; they therefore rely heavily on their native language media sources.

The media and organizations that conceptualize health education campaigns also must address issues of racism within their own infrastructures: merely including an Asian and Pacific Islander as a token image is not enough. Asian and Pacific Islander health professionals, researchers, and community activists need to be tapped into as resources for stories that affect the nation as a whole. Ignorance and a lack of cultural awareness are detrimental to the vitality and growth of the Asian and Pacific Islander community.

## Conclusion

While the U.S. is traditionally known as a "melting pot," we must be aware of, and appreciate the uniqueness of the traditional culture of each American. As the demographics of the Asian and Pacific Islander community continue to change in the United States, the health needs and status of this population regarding HIV/AIDS needs to be adequately addressed. Health professionals and policymakers must familiarize themselves with the ethnocultural issues surrounding accessible and affordable health care/AIDS services for Asian and Pacific Islander communities.

Lack of knowledge increases both the spread of HIV and paranoia. The most effective tools available are proper education and accurate information. When addressing the Asian and Pacific Islander communities, and indeed all communities of color, one must be very knowledgeable and aware of the cultural and linguistic differences that will enable one to provide effective education and services.

Two major barriers must be confronted in order to do this. One, we must overcome lack of funding, under-

standing, and sensitivity from both the public and private sectors. Two, the "model minority" myth, as perpetuated by both mainstream society and Asians and Pacific Islanders themselves, must be eliminated. Ignorance and a lack of cultural awareness is detrimental to the vitality and growth of the Asian and Pacific Islander community and to the nation as a whole. By continuing to work towards the elimination of the above barriers, we will gain a better understanding of this epidemic that continues to spread throughout this rapidly increasing segment of our society.

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# WORKING WITH HIV/AIDS

## A Siecus Annotated Bibliography of Available Print Materials for Professionals

This annotated bibliography — which promotes a positive approach to living with HIV and AIDS — is geared toward professionals presently working in education and/or the health professions. Now, ten years into the epidemic, education is taking a different turn. HIV infection no longer means swift death and, as a result, educational and counseling efforts have begun to reflect this change.

Included in this bibliography are materials that will be useful when working within the HIV/AIDS area: books, curricula, and other resources. If these resources cannot be found in your local bookstore, the store may be willing to order them for you; if not, the publisher, whose address and telephone number is provided after each listing, may be contacted directly. Many of the publishers and distributors have additional materials on HIV/AIDS and continue to produce resources on the topic, so you

may wish to be placed on their mailing list to receive notification of their publications and/or catalogs.

Although SIECUS does not distribute any of the materials listed in this bibliography — other than our own publications — they are available for use within our reference library.

This bibliography was prepared by Carolyn Paterno, SIECUS' AIDS associate, and funded through a cooperative agreement with the Centers for Disease Control. It updates and completely replaces the bibliography *AIDS and Safer Sex Education* (1988). It can be reproduced as long as SIECUS is acknowledged (please send a copy to the Publications Department for our records). A single copy can be obtained, free upon request, with a self-addressed, stamped business envelope by writing to: Publications, SIECUS, 32 Washington Place, Suite 52, New York, NY 10003, or by calling 212/673-3850.

### AIDS: THE FACTS

#### AIDS: SEXUAL BEHAVIOR AND INTRAVENOUS DRUG USE

Charles Turner, Heather Miller, & Lincoln Mosed, Editors

"Understanding the human behaviors that transmit HIV infection (and thereby AIDS), as well as the social contexts in which those behaviors occur," state the editors, "call for action by the disciplines that constitute the behavioral, social, and statistical sciences." The book is divided into three sections: Understanding the Spread of HIV Infection, Intervening to Limit the Spread of HIV, and Impediments to Research and Intervention. 1989, 589 pp., \$24.95.

The National Academy Press, 2101 Constitution Avenue NW, Washington, DC 20418; 202/334-2665.

#### UNDERSTANDING AND PREVENTING AIDS: A BOOK FOR EVERYONE

Chris Jennings

Written in clear and concise lan-

guage, this book deals with a wide range of topics, and is truly "for everyone." Tables are used effectively throughout, and the detailed chapter summaries are helpful. 1988, 230 pp., \$24.95.

Health Alert Press, PO Box 2060, Cambridge, MA 02238; 617/497-4190.

#### YOU CAN DO SOMETHING ABOUT AIDS: NEW EDITION

Sasha Alyson, Editor

From the publishing community, this book — an updated version of the first edition — is designed for those people who want to personally contribute to the battle against AIDS. 1990, 196 pp., \$1.

The Stop AIDS Project, Inc., 40 Plympton Street, Boston, MA 02118; 617/542-5679.

### PERSONAL PERSPECTIVES

#### AIDS: THE WOMEN

Ines Rieder & Patricia Ruppelt, Editors

A collection of experiences, told by women whose lives have been affected by AIDS. Mothers, sisters, wives, friends and lovers share personal accounts of their

struggles to come to terms with the disease. 1988, 251 pp., \$9.95.

Cleis Press, PO Box 8933, Pittsburgh, PA 15221; 412/731-3863.

#### EPITAPHS FOR THE LIVING: WORDS AND IMAGES IN THE TIME OF AIDS

Billy Howard, Photographer

A collection of 70 photographs of people with AIDS (PWAs), each accompanied by a personally written statement of the PWA's experience. Extremely powerful, this volume serves to remind us of the magnitude and courage of so many people. 1989, 83 pp., \$35.

Southern Methodist University Press, Box 415, Dallas, TX 75275; 214/739-5959.

#### A SHALLOW POOL OF TIME: AN HIV+ WOMAN GRAPPLES WITH THE AIDS EPIDEMIC

Fran Peavey

This book is composed of journal entries of an HIV-positive woman before and after she learns of her status. Prior to knowing her status, Peavey kept her "AIDS journal" because she thought it would be an invaluable account of personal, social, and political events for future generations. Once aware that she was HIV-positive, she began to share the range of the per-

sonal responses she experienced. Her humor, anger and honesty all contribute to this eye-opening testament to life. 1990, 154 pp., \$11.95.

New Society Publishers, 4527 Springfield Avenue, Philadelphia, PA 19143; 215/382-6543.

#### SOMEONE WAS HERE: PROFILES IN THE AIDS EPIDEMIC

George Whitmore

The personal stories of two PWAs, one buddy, and the hospital staff on an AIDS ward are combined with social and political history. Whitmore's strength is his talent for recreating atmosphere. These accounts read like a novel and are haunting in their truths. Will be valuable reading for buddies and for hospital staff, as well as for PWAs and caregivers. 1988, 211 pp., \$8.95.

New American Library, 1633 Broadway, New York, NY 10019; 212/397-8000.

## CURRICULA AND GUIDELINES

#### THE AIDS CHALLENGE: PREVENTION EDUCATION FOR YOUNG PEOPLE

Marcia Quackenbush & Mary Nelson, Editors, with Kay Clark

A collection of important information about AIDS education by 32 national and international experts. Provides guidelines for developing and implementing programs. Divided into eight sections: The Human Element; The Factual Component; Essential Elements for Prevention Education; Students Need to Know; The Religious Setting: A Natural Place for Learning; Controversy and AIDS Education; Minority Populations: AIDS Risks and Prevention; and Special Populations at Risk.

Network Publications, PO Box 1830, Santa Cruz, CA 95061-1830; 408/438-4080.

#### AIDS PREVENTION PROGRAM FOR YOUTH: INFORMATION FOR TEACHERS AND LEADERS

American Red Cross

This package includes pamphlets on various topics related to HIV/AIDS (*Drugs, Sex, and AIDS; Women and AIDS; Teenagers and AIDS; School Systems: Information for Teachers; Men, Sex, and AIDS; and Children, Parents, and AIDS*), a student workbook, a teacher's companion workbook, and a

knowledge and attitude assessment. Available from your local American Red Cross chapter.

#### HIV/AIDS EDUCATION: A CURRICULUM GUIDE FOR HEALTH CARE PROFESSIONALS

New York University Mental Health Project

A guide for a basic two-day curriculum for health care providers, which covers: Pathophysiology of HIV and HIV-Related Diagnoses; HIV-Antibody Testing and Counseling; Infection Control and Health Teaching for Persons with HIV Infection; Psychosocial Issues for Health Care Providers in Working with People Who Are HIV-Infected or Have AIDS; Psychosocial Issues of Subgroups of the Population; Neurological and Neuropsychiatric Manifestations Associated with HIV Infection; Concepts of Death and Dying Related to Working with PWAs and Health Care Providers Caring for Them; and Stress and Coping. 1989, 115 pp., \$10.

AIDS Education Center, New York University, Division of Nursing, School of Education, Health, Nursing, and Arts Professions, 429 Shimkin Hall, Washington Square, New York, NY 10003; 212/998-5332.

#### THE KIDS ON THE BLOCK

This program on AIDS prevention for grades five and up — designed to complement an existing program on sexuality education and/or family life education — is available for demonstration programs at national conferences. 1988, \$1,475 for puppets, scripts, props and follow-up activities, plus \$750 for one-day training for up to 25 teachers or dramatic actors.

The Kids on the Block, Inc., 9385-C Gerwig Lane, Columbia, MD 21406; 301/290-9095 or 800/368-KIDS.

#### LOOKING INTO AIDS

William Yarber

Much discussion in this curriculum, which is designed for middle school, is dedicated to self-esteem, assertiveness skills, and IV drug use. Includes an instructor's guide and a student handbook. The instructor's guide provides worksheets, "learning opportunities," and ways to implement an HIV/AIDS curriculum. 1989, \$9 for instructor's guide, \$2 for student handbook.

Phi Delta Kappa, PO Box 789, Bloomington, IN 47402-0789; 812/339-1156.

#### PREVENTING AIDS: A GUIDE TO EFFECTIVE EDUCATION FOR THE PREVENTION OF HIV INFECTION

Nicholas Freudenberg

This guide is divided into two sections — Planning AIDS Education Programs and Reaching Out: How to Educate Specific Population Groups about AIDS. Each chapter includes tables, which provide clear information and guidelines on the most effective and creative means for developing

programs. 1989, 217 pp., \$22, APHA members, \$17.60.

American Public Health Association, 1015 Fifteenth Street NW, Washington, DC 20005; 202/789-5600.

#### RESPONDING TO HIV AND AIDS

John Burger, Editor, National Education Association

Divided into five sections: Basics; What is the HIV Antibody Test; Guidelines for Handling Blood and Other Body Fluids in Schools; HIV, AIDS and the Need for Care and Compassion; and Saying Good-bye to Someone You Love. 1989, 28 pp., first copy is complementary, additional copies, \$2.

The Health Information Network, 100 Colony Square, Suite 200, Atlanta, GA 30361; 404/875-8819.

#### TALKING WITH TEENS

Parent-Teen AIDS Education Project

A curriculum for educating parents who will then, hopefully, educate their teenage children. In addition to basic information, there are guidelines for organizing and producing a parents meeting. 1988, 127 pp., \$150.

San Francisco AIDS Foundation, 333 Valencia Street, fourth floor, PO Box 6182, San Francisco, CA 94101-6182; 415/861-3397.

#### TEACHING AIDS: A RESOURCE GUIDE ON ACQUIRED IMMUNE DEFICIENCY SYNDROME

Marcia Quackenbush & Pamela Sargent

This revised resource guide assists teachers in integrating AIDS information into existing courses. Includes lesson plans that cover the medical, social, and legal aspects of AIDS, and provides worksheets, trouble-shooting tips, and a resource listing. 1988, 159 pp., \$19.95 plus 15% p/h.

Network Publications, PO Box 1830, Santa Cruz, CA 95061-1830; 408/438-4080.

## SAFER SEX

#### THE CONDOM BOOK: THE ESSENTIAL GUIDE FOR MEN AND WOMEN

Jane Everett & Walter Glanze

Includes a comprehensive, question-and-answer section on STDs, sexuality, and the correct use of condoms. A buyer's guide lists the condoms by product name; provides information about, and a description of, each product and its packaging; and offers a personal opinion of the condom by someone who has used it. 1987, 139 pp., \$3.95.

*Signet, 1633 Broadway, New York, NY 10019; 212/397-8000.*

#### **HOW TO PERSUADE YOUR LOVER TO USE A CONDOM...AND WHY YOU SHOULD**

*Patti Breitman, Kim Knutson, & Paul Reed*

Presents safer sex in a positive manner, while acknowledging and addressing the difficulties of adopting safer sex practices. Includes a question-and-answer section on condoms and a "how-to" section for dealing with negative responses to condom use. A resource directory is included. 1987, 83 pp., \$4.95.

*Prima Publishing and Communications, PO Box 1260 PC, Rocklin, CA 95677; 916/624-5718.*

#### **MAKING IT: A WOMAN'S GUIDE TO SAFER SEX IN THE AGE OF AIDS**

*Cindy Patton & Janis Kelly*

In a completely nonjudgmental and safe tone, this book deals with all women — heterosexual, bisexual, and lesbian. The authors remain sex-positive, yet thoroughly discuss all risk behaviors. Includes sections for sex workers and another on drug use. When flipped over, the book is in Spanish. 1988, 30 pp., \$3.95.

*Firebrand Books, 141 The Commons, Ithaca, NY 14850; 607/272-0000.*

#### **SAFE ENCOUNTERS: HOW WOMEN CAN SAY YES TO PLEASURE AND NO TO UNSAFE SEX**

*Beverly Whipple & Gina Ogden*

This book explains that safer sex does not have to be unappealing or forbidding. Nonthreatening, the book is designed to make women feel more comfortable and aware in dealing with sexual issues in light of the HIV/AIDS epidemic. 1989, 222 pp., \$16.95.

*McGraw-Hill Book Company, 11 W. 19th Street, New York, NY 10011; 212/512-2000.*

## **FOR YOUNG PEOPLE AND PARENTS**

#### **AIDS: TRADING FEARS FOR FACTS — A GUIDE FOR TEENS**

*Karen Hein, MD & Theresa Foy DiGeronimo*

The authors, writing especially for teens, are sensitive to the needs, fears, and concerns of this age group. Pronunciation of medical terms is given as the terms are introduced in the text for

discussion, and photographs are used effectively, which makes this an attractive book. Includes a resource directory. 1989, 206 pp., \$3.50.

*Consumer Reports Books, 51 E. 42nd Street, New York, NY 10017; 212/983-8250.*

#### **CHILDREN AND THE AIDS VIRUS — A BOOK FOR CHILDREN, PARENTS, AND TEACHERS**

*Rosemarie Hausherr*

Utilizing beautiful black-and-white photos, this book explains the facts about HIV/AIDS and its transmission. Large print is used for younger children and, for older children, in-depth discussions in smaller print are included at the bottom of the page. 1989, 48 pp., \$4.95.

*Clarion Books, 52 Vanderbilt Avenue, New York, NY 10017; 212/972-1190.*

#### **DOES AIDS HURT?**

*Marcia Quackenbush & Sylvia Villarreal*

The authors' intention in writing this book was "to offer children hope in a world that has no guarantees" and "to support parents, teachers, and others in guiding children through life with one less fear." They stress that a basic understanding of human sexuality is essential in learning about AIDS, and suggest the means for facilitating this understanding. 1988, 149 pp., \$14.95.

*Network Publications, PO Box 1830, Santa Cruz, CA 95061-1830; 408/438-4081.*

#### **FRIENDS FOR LIFE — THE KIDS ON THE BLOCK BOOK SERIES**

*Barbara Aiello & Jeffery Shulman*

This story, in which the advisor of the student video club is discovered to have AIDS, examines the response of the community, the students, and the advisor herself. There is a positive outcome eventually, however not before some difficult issues are faced. 1988, 48 pp., \$12.95.

*Twenty-First Century Books, 38 S. Market Street, Frederick, MD 21701; 301/698-0210.*

#### **WHAT DO OUR CHILDREN NEED TO KNOW ABOUT AIDS?: GUIDELINES FOR PARENTS**

*Alissa Ralston*

Well-organized and compassionate, these guidelines stress four basic factors that aid a child in developing coping skills when dealing with HIV issues — a strong sense of self-esteem, a value system, decision-making ability, and communication skills. Included is an explanation of what children need to know about at particular ages. 1988, 28 pp., \$4.95 (includes postage).

*HIV Education, 567 Cedarberry Lane, San Rafael, CA 94903; 415/472-5852.*

## **FOR CAREGIVERS, FAMILIES, AND PEOPLE WITH AIDS**

#### **AIDS: CAREGIVER'S HANDBOOK**

*Ted Eidson, Editor*

This book, which deals with caring for a person with HIV/AIDS, includes articles by various authors on a wide range of topics. Its clear and well-organized format makes locating needed information easy. 1988, 331 pp., \$19.95.

*St. Martin's Press, 175 Fifth Avenue, New York, NY 10010; 212/674-5151.*

#### **AIDS: A SELF-CARE MANUAL — AIDS PROJECT LOS ANGELES**

*Betty Clare Moffatt, Judith Spiegel, Steve Parrish, & Michael Helquist, Editors*

A very comprehensive guide that could be of use to everyone. The sections of the book are divided according to perspectives: social-psychological, medical, treatment, prevention, self-care, practical, spiritual, healing, and self-care resources (the latter is extensive and includes forms that could be used to keep affairs/records in order). 1987, 306 pp., \$12.95, from APLA, \$6.47.

*IBS Press, 2339 28th Street, Santa Monica, CA 90405; 213/450-6485 or APLA, 6721 Romaine Street, Los Angeles, CA 90038; 213/926-1600.*

#### **AMERICAN FOUNDATION FOR AIDS RESEARCH (AmFAR) DIRECTORY OF EXPERIMENTAL TREATMENTS FOR AIDS AND ARC**

Each treatment included in this directory gives the chemical name of the drug; its manufacturer; a contact person; the status of the drug with the Food and Drug Administration; a general description of the drug's mechanism of action; clinical trial results; and the side effects. Published quarterly. Single copies, \$10, subscription, \$30.

*National AIDS Information Clearinghouse, 800/458-5231 or AmFAR, 1515 Broadway, Suite 3601, New York, NY 10036; 212/719-0033.*

#### **FAMILY AIDS SUPPORT NOTEBOOK**

*Parents and Friends of Lesbians*

*and Gays*

A notebook intended "to provide families and friends of HIV-infected people with a broad base of issues related to each of four topics: medical/treatment issues, psychosocial concerns for caregivers, religious responses, and legal/legislative issues." Innovative and supportive, this guide also could be used by hospices, hospital social work departments, home nursing services, ministers, and doctors. 1989, 86 pp., suggested donation, \$12.

*Family AIDS Project, Federation of Parents and Friends of Lesbians and Gays, PO Box 27605, Washington, DC 20038-7605, 202/483-4744.*

#### LIVING WITH AIDS — REACHING OUT

*Tom O'Connor & Abmen Gonzalez-Nunez*

This book, offering a holistic approach to AIDS care, emphasizes nutrition, body manipulation, and psychosocial issues. Included are many tables and illustrations for easy reference. 1987, 426 pp., \$18.95.

*Corwin Publishers, PO Box 2806, San Francisco 94106; 415/621-4346.*

#### SERENITY — CHALLENGING THE FEAR OF AIDS — FROM DESPAIR TO HOPE

*Paul Reed*

These essays chronicle one man's journey through the crippling fear of AIDS. He begins, "I knew I somehow had to make peace with it (the dispirit I felt was overwhelming), to find a positive way through the fear and back into the spirit of life I had once known." Reed's thoughts are inspirational and comforting. 1987, 97 pp., \$5.95.

*Celestial Arts, PO Box 7123, Berkeley, CA 94607; 415/845-8414.*

#### SURVIVING AND THRIVING WITH AIDS: COLLECTED WISDOM, VOL. II

*Michael Callen, editor*

This second volume is described by the editor as "an anthology of our attempts to cope with AIDS. It is a slice of lives which captures what it is like to live with AIDS in America in the late 80s." Various treatments are dealt with, in-depth, by PWAs who have used them, and by those who have administered them. Other sections included are: People of Color and AIDS; AIDS and IV Drug Use; Family and Friends; Love, Sex, and AIDS; Pediatric AIDS; Dealing with Disability, Social Security, and Medicaid; and Helpful Hints. 1988, 352 pp., \$20, free for PWAs.

*People With AIDS Coalition, Inc., 31 W. 26th Street, New York, NY 10010; 212/532-0290.*

### SOCIAL AND POLITICAL PERSPECTIVES

#### PRIVATE ACTS, SOCIAL CONSEQUENCES

*Ron Bayer*

Written by a medical ethicist, this book examines the politics of the AIDS epidemic since the early 80s. Topics covered include the politics of privacy, safety, identification, exclusion, control, persuasion, and public health. 1989, 282 pp., \$22.95.

*The Free Press/Macmillan, Inc., 866 Third Avenue, New York, NY 10022; 212/702-2000.*

#### REPORTS FROM THE HOLOCAUST

*Larry Kramer*

Controversial, and often insightful, Kramer's collection of writings (dating back to 1978) capture the emotions engendered by the AIDS crisis. The collection, including the essay, "Report From the holocaust," is fascinating and provocative. 1989, 284 pp., \$18.95.

*St. Martin's Press, 175 Fifth Avenue, New York, NY 10010; 212/674-5151.*

#### TAKING LIBERTIES: AIDS AND CULTURAL POLITICS

*Erica Carter & Simon Watney, Editors*

This collection of writings, the result of a conference at the Institute of Contemporary Arts, unites diverse contributions into a "common understanding of AIDS as fundamentally challenging the meanings, values and practices in which our experiences of sexuality, love, the body, life, death and physical processes are grounded." 1989, 236 pp., \$14.95.

*Serpent's Tail, 4 Blackstock Mews, London N4, England.*

*Constitution Avenue NW, Washington, DC 20418; 202/334-2665.*

#### PREVENTING AIDS, THE DESIGN OF EFFECTIVE PROGRAMS

*Ronald Valdiserri*

Sections include: Historical Variables Influencing Prevention Programs; Theoretical Foundations of AIDS Prevention Programs; Identifying the Targets of Prevention, Planning, and Implementing — A Case Study Approach; Role of HIV-Testing; Evaluating Programs; and Barriers to Programs. 1989, 304 pp., \$15.

*Rutgers University Press, 109 Church Street, New Brunswick, NJ 08901; 201/932-7764.*

#### PRIMARY PREVENTION OF AIDS — PSYCHOLOGICAL APPROACHES

*Vickie Mays, George Albee & Stanley Schneider, Editors*

Divided into five sections: Primary Prevention in Public Health: Problems and Challenges of Behavior Change as Prevention; The Faces of AIDS: What We Are Trying to Prevent; Theories, Models and Research on Health, Risk and Decision-Making; Prevention in Targeted Populations; and An Agenda for Psychosocial Training and Research. 1989, 425 pp., \$39.95.

*SAGE Publications, Inc., 2111 W. Hillcrest Drive, Newbury Park, CA 91320; 805/499-0721.*

#### WORKING WITH AIDS — A RESOURCE GUIDE FOR MENTAL HEALTH PROFESSIONALS

*Michael Helquist, Editor*

Each chapter includes: an overview of how AIDS affects a given population group; a discussion of pertinent treatment issues; case histories that illustrate how AIDS can disrupt an individual's life; interventions and counseling plans; a set of discussion questions for use by individuals or for use during staff meetings and inservices; and a cross-reference guide directing the reader to related issues discussed elsewhere in the guide. 1987, 299 pp., \$15.

*University of California/San Francisco, The AIDS Health Project, Box 0884, San Francisco, CA 94143-0884; 415/476-6430.*

### LEADER RESOURCES

#### AIDS AND HIV: COUNSELING IN FAMILY PLANNING PRACTICE

*Terry Beresford, Wayne Pawlowski & Joan Mogul*

There are two sections in this guide — Counseling Skills and Resources. Includes factual material, attitude assessment exercises, and counseling tips. 1988, 61 pp., \$12.50.

*Planned Parenthood of Washington, DC, 1108 16th Street NW, Washington, DC 20036; 202/347-8500.*

#### CONFRONTING AIDS: UPDATE 88

*Institute of Medicine, National Academy of Sciences*

This compendium updates the October 1986 Institute of Medicine report *Confronting AIDS: Directions for Public Health, Health Care, and Research*. The two books together provide definitive information on what we now know about HIV infection and its epidemiology, education, care of people infected with HIV, drugs, and the international aspects of the AIDS epidemic. 1988, \$15.95.

*National Academy Press, 2101*

### BIBLIOGRAPHIES AND DIRECTORIES

#### AIDS BIBLIOGRAPHY SERIES: AIDS 1989

*David Tyckoson*

An evaluative selection of fully annotated articles — all readily available — with key articles highlighted (undergraduate reading level and English language only). Topics include: medical and health care aspects, hemophilia, women, children, minorities, vaccine research schools, the workplace, and the insurance industry. 1989, 138 pp., \$19.50.

*Oryx Press, 2214 N. Central at Encanto, Phoenix, AZ 856004-1483; 800/457-6799.*

#### AIDS EDUCATION VIDEOTAPES: ANNOTATED BIBLIOGRAPHY

*Prepared by NOVA Research Company  
for the National AIDS Demonstration  
Research Project*

Lists 60 videotapes concerning a variety of topics as they relate to HIV. Each reference includes basic facts about the film, cost, and ordering information, as well as reviewers comments. 1989, 61 pp., free.

*NOVA Research Company, 4720  
Montgomery Lane, Suite 210, Bethesda,  
MD 20814; 301/986-1891.*

#### AIDS INFORMATION SOURCE- BOOK: SECOND EDITION 1989-90

*H. Robert Malinowsky & Gerald Perry,  
Editors*

Alphabetically lists national and community-based AIDS organizations by type and state. Includes a comprehensive bibliography, which lists articles; books; brochures/pamphlets; curriculum/education programs; directories; fiction; films/video/audio resources; online databases; and periodicals. Also includes a subject index. 1989, 215 pp., \$29.50.

*Oryx Press, 2214 North Central at  
Encanto, Phoenix, AZ 856004-1483;  
800/457-6799.*

#### AIDS: LOOKING FORWARD/LOOK- ING BACK

*Prepared by Carolyn Patierno, SIECUS'  
AIDS Associate*

A SIECUS annotated bibliography of AIDS-related resources for the general public.

*SIECUS, 32 Washington Place, Suite  
52, New York, NY 10003; 212/673-  
3850.*

#### LEARNING AIDS

*The American Foundation for AIDS Re-  
search*

Comprehensive in scope, this resource directory lists materials by audience, provides a title index, and offers abstracts and evaluations of all materials listed. 1989, 270 pp., \$24.95.

*R.R. Bowker, 245 W. 17th Street,  
New York, NY 10011; 800/521-8110 or  
212/337-6934.*

#### WOMEN AND AIDS: AN ANNOTATED BIBLIOGRAPHY

*Prepared by NOVA Research Company for  
the National AIDS Demonstration Research  
Project*

Divided into three parts — resources for project staff, client-education resources, and posters — this book covers a wide variety of topics related to the prevention of AIDS among female sexual partners of intravenous drug users. 1989, 233 pp., free.

*NOVA Research Company, 4720  
Montgomery Lane, Suite 210, Bethesda, MD  
20814; 301/986-1891.*

### FOR MORE INFORMATION

AIDS Action Council  
729 8th Street SE, Suite 200  
Washington, DC 20003  
202/547-3101

AIDS Information  
U.S. Public Health Services  
Office of Public Affairs, Room 721-H  
200 Independence Avenue SW  
Washington, DC 20201  
202/245-6867

AIDS Information Exchange  
U.S. Conference of Mayors  
1620 Eye Street NW  
Washington, DC 20006  
202/293-7330

AIDS Public Education Program  
American Red Cross  
1730 D Street NW  
Washington, DC 20003  
202/639-3223

AIDS-Related Discrimination Unit  
American Civil Liberties Union  
132 W. 43rd Street  
New York, NY 10036  
212/944-9800 x545

American Foundation for AIDS Research  
1515 Broadway, Suite 3601  
New York, NY 10036  
212/719-0033

ETR Associates (Network Publications)  
1700 Mission Street, Suite 203  
PO Box 1830  
Santa Cruz, CA 95061  
408/438-4080

Gay Men's Health Crisis  
PO Box 274  
129 W. 20th Street  
New York, NY 10011  
212/807-6655

Institute for the Protection of  
Lesbian and Gay Youth  
401 West Street  
New York, NY 10014  
212/633-8920

Lambda Legal Defense and  
Education Fund  
666 Broadway, 12th Floor  
New York, NY 10012  
212/995-8585

National AIDS Network  
2033 M Street, Suite 800  
Washington, DC 20036  
202/293-2437

National Association of People  
With AIDS  
PO Box 65472  
Washington, DC 20335  
202/483-7979

National Lesbian and Gay  
Health Foundation  
PO Box 65472  
Washington, DC 20035  
212/797-3708

National Hemophilia Foundation  
110 Greene Street, Room 406  
New York, NY 10012  
212/219-8180

National Leadership  
Coalition on AIDS  
1150 17th Street NW, #202  
Washington, DC 20036  
202/429-0930

Planned Parenthood Federation  
of America  
810 Seventh Avenue  
New York, NY 10010  
212/541-7800

Sex Information and Education  
Council of the U.S.  
32 Washington Place, Suite 52  
New York, NY 10003  
212/673-3850

National AIDS Hotline  
800/342-AIDS

National AIDS Information  
Clearinghouse  
800/458-5231

National Gay Task Force  
800/221-7044

AIDS Crisisline  
800/221-7044

STD National Hotline  
800/227-8922

# BOOKS

## THE REAL TRUTH ABOUT WOMEN AND AIDS

Dr. Helen Singer Kaplan, MD, PhD  
New York: Simon & Schuster, Inc.,  
1987, 192 pp., \$4.95.

## ADVICE FOR LIFE: A WOMAN'S GUIDE TO AIDS RISKS AND PREVENTION

Chris Norwood  
New York: Pantheon, 1987, 192 pp., \$5.95.

## WOMEN & AIDS

Diane Richardson  
New York: Routledge Chapman & Hall, 1987, 160 pp., \$29.95, \$9.95.

After hearing little about the impact of AIDS on women before 1986, books on the subject finally began to appear. Three of the first paperback books to deal exclusively with the subject of AIDS were: Dr. Helen Singer Kaplan's *The Real Truth About Women and AIDS*; Chris Norwood's *Advice for Life*; and Diane Richardson's *Women & AIDS*.

There are numerous problems, both factual and political, with *The Real Truth About Women and AIDS*. For example, Dr. Kaplan infers that women have to worry about seminal fluid crawling into their vaginas from their pubic hair or slipping in through their nipples — assertions that exhibit an unfamiliarity with the "virility" of the virus, (the virus does not survive long) and which are patently ridiculous:

The AIDS virus and AIDS-infected cells can enter your body only if they come in contact with your "wet" type of skin, or mucus membranes, which cover your mouth, nose, nipples, rectum, anus, and genital organs. These are the vulnerable entrance ports for the virus....The female sexual organs are covered by moist, vulnerable mucus membranes that afford[s] the virus an easy point of entrance into your body, should some infected lymphocytes or free virus particles land there....the AIDS virus is much smaller than the relatively gigantic sperm, and so it can probably get into the moist pubic hair and escape out over the rim during thrusting much more easily....infected fluids can seep out over the rim of the condom, or remain on his moist pubic hair and yours or seep out of his penis

before he puts on his condom or after he removes it. Also keep in mind that semen is not the only body fluid that contains AIDS virus particles and infected cells. These are also likely to be present in his saliva, pre-ejaculatory secretions and on his mucus membranes.

Furthermore, Kaplan claims that the majority of women who are partners of HIV-infected intravenous drug users are already infected, and that bisexual men pose the greatest risk to women. She also advises women to get their male partners to wash their bodies with undiluted alcohol or a dilute solution of Lysol:

The rule is "keep it dry." If you should "wet" each other, you must get up at once and wash any part of your body that has been in contact with the potentially infected fluid. Scrub with soap and water in addition to disinfecting the area with undiluted rubbing alcohol or a dilute solution of Lysol.\* (\*Do not put rubbing alcohol, Lysol, or any other strong disinfectant on your genitalia, and never douche your vagina with those liquids, or you will get a nasty inflammation. Do not let any potentially infected secretions get there in the first place!) This is important. It is not so dangerous if his semen gets on your hands, especially if it gets on the thick skin of the palms of your hands which is less likely broken and more protective than the thin skin on the other parts of the body. But if you do not wash it off it will stay on your hands, and if you bite your nails, or eat something with your fingers a few hours later, some virus might have survived and you could become infected.

For those who do not read the fine print, the use of lysol could be a "real" safer sex measure — and only in the small footnote does she say not to use it on penises and vaginas. Any woman who might persuade her partner to try it would probably never see him again.

Cuba, where people with AIDS are quarantined permanently, is held up by Kaplan as an example of "enlightened" handling of individuals with AIDS. She also suggests that the civil rights of heterosexuals in the United States may be in conflict with the civil rights of gay men; if civil rights are not universal, they are not civil rights.

Women in Kaplan's scheme are "sweet-givers" (my word) — moving targets for men who are portrayed as lethal time bombs:

Women must learn to take care of themselves in all areas of their lives, but this is particularly difficult when it comes to sex. Because we have been trained to be "good girls" from infancy on, it is hard for many well-brought-up women to assert themselves in this sensitive, vulnerable matter of sexuality. And the irony and tragedy is that the sweetest, the nicest, the gentlest, the most loving, the most sensitive young women, the women who do not wish to hurt a man's feelings by questioning his in-

tegrity, or his masculinity, who find it easier to give than take, who hate to ask for anything that is not freely volunteered — these are the women who are the most likely victims of this plague.

Kaplan casts women as the dual victims of public agencies and men and presents HIV testing as the cornerstone of risk reduction efforts. And, she promotes testing, not just for women, but for adolescents as well. (She suggests that testing centers be set up in high schools.)

Her advice to women — that they make sexual decisions based on HIV-antibody test results — not only creates a false sense of security in a population with a low seroprevalence, but it also de-emphasizes confronting the need for changes in sexual behaviors that are necessary if the spread of HIV is to be halted. Kaplan further damages the case for the need for changes in sexual behavior by admonishing women to ask men to be tested rather than to wear condoms, suggesting that condoms take "all the romance and spontaneity out of sex."

Norwood's book, *Advice for Life*, although feminist in tone, addresses women as deceived victims of men and the public health establishment. Her message, that women should undergo HIV-antibody testing and also insist that men do so as well in order for the extent of the disease to be measured, is an insensitive response to the emotional trauma and social isolation experienced by women who are at highest risk of being infected.

Norwood implies that knowing one's HIV-antibody status leads to sexual behavior changes that promote prevention. Research indicates that knowing one's HIV-antibody status does not always result in sexual risk reduction. And, anyone who has worked with IV drug users knows that this is a false assumption. Active needle users often react to the news that they are seropositive by increasing their risk-taking behavior.

Norwood and Kaplan both see testing as the cornerstone of prevention for women. However, neither addresses the heavy cost of training and hiring professional counselors (needed to provide adequate pre- and posttest and long-term follow-up counseling); or the growing concern among scientists that high-risk individuals with negative antibody tests may in fact be infected but not producing antibodies when they are tested; or the psychosocial impact of knowing that one is infected on an individual woman's (or man's) life.

Neither author addresses the fact that

if men will lie about their risk, they will lie about their antibody test results, and that no professional counselor can divulge a test result without permission of the individual being tested.

Both authors present themselves in the role of protectors of unsuspecting, gullible women. Kaplan, in particular, writes somewhat in the mode of an oracle, using the pronoun "I" 19 times in one and three-quarter pages of her preface. In their role as protectors, Kaplan and Norwood fuel distrust of health education efforts and men — although Norwood recognizes that men must be included in heterosexual education efforts, something that we are not seeing. Such distrust is a major obstacle in reaching the women most at risk — the poor minority women in our inner cities who live in communities where behaviors that put individuals at risk are not always dealt with openly. What is needed in these communities are approaches that help to counteract distrust and that promote communication based on mutual interest in HIV/AIDS prevention.

It is the third author, Diane Richardson who in her book, *Women & AIDS*, addresses the impact of HIV/AIDS on communities and its relationship to the spread of HIV/AIDS among women. She notes the role of drug use in HIV transmission, and discusses the importance of understanding what sexuality means to men and to women.

Unlike Kaplan and Norwood, Richardson confronts the tremendous ambiguity, the lack of clear, easy answers to the questions posed by HIV/AIDS, and notes that individual women have to take responsibility for their protection and must decide what level of risk they can live with personally. In analyzing the sociocultural conditions of most at-risk women, she examines their different roles as lovers, mothers, caretakers, and health care workers, and portrays their sorrow, isolation, emotional distress, and the life opportunities lost because of AIDS.

Richardson, an Englishwoman, frames the impact of HIV/AIDS on women in a moral and political context, and comments on the Reagan administration's handling of the drug problem and the impact it had on the spread of HIV/AIDS among women. She also notes that there is little evidence for portraying female sex workers as "vectors" for transmitting the disease (although they continue to be so portrayed by the press and the AIDS-right). In the United States the

evidence, thus far, is that most HIV infection is related to IV drug use.

Most importantly, Richardson identifies the real crux of AIDS for women: the ability of women to protect themselves is determined by the degree of control a woman has over her sexuality, and AIDS has challenged that control.

*Reviewed by Dooley Worth, PhD, consultant for the National Institute on Drug Abuse.*

#### AIDS: THE WOMEN

Ines Rieder and Patricia Ruppelt, Editors  
Pittsburgh, PA: Cleis Press, 1988,  
250 pp., \$24.95, \$9.95.

"All pain is shattering; but when it's shared, at least it is no longer a banishment. It is not out of morose delectation, nor out of exhibitionism, nor out of provocation that writers often tell of hideous or deeply saddening experiences: through the medium of words they render these experiences universal and allow their readers, deep in their private unhappiness, to know the consolation of sisterhood." — Simone de Beauvoir, *Introduction to the book*

This book, a compelling collection of the personal experiences of women throughout the world who have been affected by the HIV/AIDS crisis in many different ways completely absorbed this reviewer. The title and cover photograph alone are striking in their simplicity and impact.

*AIDS: The Women* is not about basic AIDS 101 facts. It is not about at-risk behavior and transmission. It is not about testing, treatments, and cures.

It is about women. It is about human emotion in the face of great loss and turmoil. And, it is about courage and hope. It is at once devastating and joyful, disturbing and comforting.

The book is divided into seven sections: Family, Lovers and Friends; Women with AIDS/ARC and HIV-Positive Women; Professional Caregivers; Lesbians Facing AIDS; Prostitution in the Age of AIDS; Becoming Visible: Women AIDS Educators; and AIDS Prevention Policies. The stories are so diverse, yet a strong thread of familiarity runs throughout the book which provides it with cohesiveness.

The collection of stories can be read from cover to cover, or from story to story. In either case, one anxiously awaits returning to the book. With so few books written for women regarding HIV and AIDS — and even fewer good ones — the women involved in this project have done a great service for all those in need of support and consolation.

*Reviewed by Carolyn Patierno, SIECUS AIDS associate.*

# AUDIO-VISUALS

The Following Audiovisuals Were Reviewed and Written By Carolyn Patierno, SIECUS AIDS Associate

#### AIDS: EVERYTHING YOU AND YOUR FAMILY NEED TO KNOW...BUT WERE AFRAID TO ASK

HBO/Studio Productions, 120A E. 23rd Street, New York, NY 10010, For purchasing information: Ambrose Video, 1989, 212/696-4545; 1/2" video, \$99.95, 1/4" video, \$149.95.

As the title indicates — *AIDS: Everything You and Your Family Need to Know...But Were Afraid to Ask* — was produced with the family unit in mind. Through the course of the video's 39 minutes, former Surgeon General C. Everett Koop fields a wide range of questions from "people on the street"; his purpose is to answer as many questions as possible from as diverse a group as possible. Responding in his usual frank and down-to-earth manner, he attempts to clarify some misconceptions regarding HIV infection and AIDS.

Dr. Koop's attempts are generally successful. For example, he reiterates the modes of transmission, as he is repeatedly questioned in this area, and, after refuting every thought-possible mode of transmission (one man asks if it is possible to contract HIV if a seropositive person, who has a cut on his/her buttocks, uses a toilet and immediately afterwards a seronegative person, who also has a cut on his or her buttocks, uses the same toilet). Indeed, every base seems to be covered.

However, for the same reasons that this video seems meritorious, it also seems to have drawbacks. By attempting to cover such a broad range of information, some of the more complicated questions are answered only in skeletal detail, which leaves viewers with incomplete information. This sketchiness is also confusing at points. For example, Dr. Koop addresses the question of the "infectability of menstrual blood." In his response, it is unclear whether he is addressing the risk of the woman who is menstruating, or the risk of her sexual partner, and he

does not explain the risk itself. There are several other instances of vagueness. It possibly would have been best to have had fewer questions and to have allocated more time for the answers.

The video is lengthy and the presentation becomes somewhat tedious early on. And, visually, there is no variation: viewers are shown the "person on the street" who is asking the question and then are brought into Dr. Koop's office for the response.

Despite its numerous drawbacks, however, *AIDS: Everything You and Your Family Need to Know...But Were Afraid to Ask* does provide an extensive amount of information useful to an audience with a marginal knowledge base.

#### SERIOUSLY FRESH

AIDSfilms, 50 W. 34th Street, #6B6, New York, NY 10001, 212/629-6288. Distributor: Select Media, 212/431-8923, 1/2" video, \$65 plus \$10 p/h.

Finally, finally, an AIDS film has been produced that strikes more than a chord of reality. It also strikes chords that resonate with professionalism and integrity. Further, it does this without patronizing the characters in the video or those viewing the video. Even the music is terrific.

*Seriously Fresh* focuses on the lives of four young black men, Ray, Jazzy Jay, Billy, and Darrell, who have grown up together, and their slightly older friend, Kenny, who, attending college on a basketball scholarship, has become sick with AIDS-related illnesses. Ever the picture of health and, as he says, the "downest guy in the neighborhood," the news is shocking to his friends; each reacts differently to his diagnosis.

The video covers a lot of ground — family relations, drug use, safer sex and gay issues — to name a few. However, what makes this video really work is the way that it deals with the human issues — fear, rejection, confusion, and anger — which are met with information, acceptance, support, and hope. One of the young men, Ray, has begun to use IV drugs. Conflict arises when his older brother becomes concerned about his use of drugs and attempts to make him understand the grave consequences. One experiences the great concern and care of his family in the discussion that ensues. The

young man with HIV/AIDS, Kenny, discloses to his friend. The confidant, Billy, expresses concern for his own health. Kenny does not understand why, as he knows that Billy does not use drugs. Not without some visible apprehension, Billy admits that he has "been with a few guys." Instead of the rejection he expects, his friend responds by saying, "Before this happened to me, I would've dissed you. But I understand...I mean these things that have happened to me recently...you just take care of yourself." The two clasp hands in a gesture of mutual support. Finally, in the last scenario shown, one of the young men, Jazzy Jay, prepares his "condom rap" — for a young woman with whom he would like to have sexual intercourse — by practicing in his bathroom mirror while his younger brother peeks through the key hole and giggles at his brother's antics.

The video is really funny and I laughed a great deal. It is somehow a relief to know that, as horrible as this whole crisis is, humor can still be drawn on in facing the situations in which we find ourselves.

#### VIDA

AIDSfilms, 50 W. 34th Street, #6B6, New York, NY 10001, 212/629-6288. Distributor: Select Media, 212/431-8923, 1/2" video, \$65 plus \$10 p/h.

*Vida*, available in both Spanish and English, is designed for use in Latino communities. The story is sensitively presented, the acting is very good, and technically *Vida* is excellent.

The story takes place in an urban setting. Elsie, a young woman, has just begun dating Luis, whom she does not know very well but knows that she wants to pursue a relationship with him. Friends and family, aware of her new involvement, tease her as she is having her hair cut. During the mayhem, she sees her friend, Blanca, across the street from the beauty salon. Blanca, obviously very ill, needs assistance walking. Blanca has AIDS, which frightens Elsie so much that she has been unable to tell her close friend, Lucy. When Lucy confronts Elsie and asks why she had not shared the bad news, Elsie responds by saying that she cannot even say the word, "AIDS." Lucy then spends some time stressing the importance of condom use with Elsie and tries to empower her friend by telling her that her life is worth protecting and that she has a family to think about as well; finally, she advises, "Don't wait until you're in bed to talk about it."

The interactions between the two young women will be very effective in initiating

discussion in group settings. Two very different personalities and, therefore, points of view are presented. Also, Lucy confronts Elsie because she cares for her, and eventually her message gets through. Elsie takes a strong stand in dealing with Luis.

The story encourages peer education and, in fact, gives young people permission to confront their friends with directness. It goes one step further when we see how self-empowerment translates into greater compassion for PWAs. Elsie decides to visit Blanca and bring her food; with great resolve, she states that she should have done this long ago.

This is a very valuable videotape. It deals clearly with the treatment of PWAs, self-empowerment, condom use, and negotiating skills. However, staff viewers, Raquel Burgos and Jeanette Reyes, pointed out that Luis is not a sympathetic character and that his response is extreme. Therefore, it may have been easier for Elsie to resist his demands that they have intercourse without a condom; saying "no" to a "nice guy" is more difficult than saying "no" to someone like Luis.

## Choices: In Sexuality with Physical Disability

(16 mm & Video/Color/60 Mins.)

Produced for:  
Institute of Rehabilitation Medicine  
New York University Medical Center  
Joan L. Bardach Ph.D., Project Director  
Frank Padrone Ph.D., Co-Director

...Choices is a film which can be used time and time again in rehabilitation facilities human sexuality programs and in any group where issues of sexual interaction and adjustment to a disability are being discussed. If both parts cannot be purchased, Part 1 is a tremendously good discussion starter and should not be missed . . .

**Pam Boyle, Coordinator:** Reproductive Health and Disabilities Program of the Margaret Sanger Center of Planned Parenthood, NYC.



Mercury Productions

907 Broadway

NYC 10011 (212) 869-4073

## Conference and Seminar Calendar

**POST SECONDARY EDUCATION AIDS CONFERENCE, April 17, 1990.** Albany, New York. Contact: Marie Haase, New York Education Department, Office of Higher and Continuing Education, Cultural Education Center, 5B68, Albany, NY 12230, 518/474-5705.

**CENTER FOR EARLY ADOLESCENCE 1990 TRAINING SCHEDULE.** Parent Education Workshop, "Living with 10 to 15 Year Olds: A Parent Education Curriculum," April 18-20 (New York, NY); July 11-13 (Chapel Hill, NC); July 25-27 (San Francisco, CA); October 17-19 (Chapel Hill, NC); Program Planning Workshop "3:00 to 6:00 PM: Planning Programs for Young Adolescents," November 7-9 (Chapel Hill, NC). Will teach participants how to conduct their own training sessions. *Parent Education* will focus on planning, coordinating, and leading parent groups; *Program Planning* will provide a process for training staff, conducting self-assessment, and planning new or improved programs. Contact: Center for Early Adolescence, University of Carolina at Chapel Hill, Suite 211, Carr Mill Mall, Carrboro, NC 27510, 919/966-1148.

**"PREVENTION 90: ASSURING THE PUBLIC'S HEALTH," April 19-22, 1990.** Sponsored by the American College of Preventive Medicine and the Association of Teachers of Preventive Medicine. Contact: Kay Doggett, Prevention 90, 1030 15th Street NW, Suite 410, Washington, DC 20005, 202/789-2928.

**13TH ANNUAL CONFERENCE — EASTERN REGION — SOCIETY FOR THE SCIENTIFIC STUDY OF SEX, April 20-22, 1990.** Keynote speaker will be Jeannie Rosoff, president of The Alan Guttmacher Institute. Plenary sessions will cover AIDS, reproductive and sexual rights, prostitution, and other topics. Omni Norfolk Hotel, Norfolk, Virginia. Contact: Dr. Patricia Bartholow Koch, Meeting Chair, 221 Hubler Road, State College, PA 16801, 814/863-2241.

**FOUR ESSENTIAL SEMINARS FOR NURSES AND OTHER HEALTH CARE PROFESSIONALS.** "Sexuality: Critical Issues for Clients with Mental Illness," April 25 (Charlottesville, VA); April 28 (Ashland, VA); May 25 (Lynchburg, VA). Designed for psychiatric nurses, LPNs, nursing assistants, mental health counselors, sexuality educators, and social workers, to increase skills and confidence so that more holistic care and strategies can be provided for implementing and conducting sexuality education developed for clients with mental illness.

**"Rape Trauma Syndrome: The Aftermath of Rape, Incest, and Other Forms of Sexual Assault," May 30, 1990.** Hampton, Virginia. A one-day workshop to help participants differentiate between rape trauma syndrome, the silent, and the compound reaction; formulate and implement a plan of care for rape survivors; develop practical and successful approaches in acute and long-term settings; and provide interventions useful in conducting individual and group psychotherapy. The Holiday Inn at all locations. Contact: Informatic Systems, Inc., 3555 Ponds Wood Drive, Chesapeake Beach, MD 20732, 202/583-0559, fax 301/535-3376.

**THE AMERICAN ORTHOPSYCHIATRIC ASSOCIATION'S 67TH ANNUAL MEETING, "CHALLENGING ESTABLISHED DOCTRINES: THE IMPACT OF SOCIETAL AND CULTURAL FORCES ON MENTAL HEALTH," April 25-29, 1990.** Planned are 13 full-day institutes, workshops, and panels, covering more than 90 subject areas and issues. General sessions, workshops, panels, poster groups and A/V sessions will be held during the first three days; the last two days will be full-day institutes. Topics will include mental health funding, interven-

tion research, education, homelessness, immigration policies, schools, and family resources. Fontainbleau Hotel, Miami Beach, Florida. Contact: ORTHO, 19 W. 44th Street, Suite 1616, New York, NY 10036, 212/354-5770.

**THE THIRD ANNUAL AIDS MEDICINE AND MIRACLES CONFERENCE, "TURNING POINT: MEDICAL, POLITICAL AND SPIRITUAL," May 3-6, 1990.** Dr. Elisabeth Kübler-Ross will give the keynote speech and twice-offered workshops will present diverse approaches to healing, treatment, and caring for PWAs. Clarion House, Boulder Colorado. Contact: Alec Tsoucatos, AIDS, Medicine and Miracles, Inc., Mapleton Terrace Building, 2033 11th Street, Suite #2, Boulder, CO 80302, 303/447-8777.

**THE 14TH ANNUAL MEETING OF THE NATIONAL ABORTION FEDERATION, "REACHING OUT: SPEAKING FOR ABORTION IN THE 90s," May 6-8, 1990.** Westin Peachtree Plaza, Atlanta, Georgia. Contact: Maria T. Pao, Program Assistant, NAF, 1436 U Street NW, Suite 103, Washington, DC 20009, 202/667-5881, fax 202/667-5890.

**THE THIRD ANNUAL AMERICAN MEDICAL ASSOCIATION NATIONAL CONGRESS ON ADOLESCENT HEALTH, "PREPARING FOR LEADERSHIP," May 8-10, 1990.** Contact: Arthur Elster, American Medical Association, Department of Adolescent Health, 535 North Dearborn Street, Chicago, IL 60610, 312/645-5540.

**"SEXUALLY TRANSMITTED DISEASES IN THE WORLD OF AIDS," May 9-11, 1990.** Sponsored by the Royal Society of Medicine, London, United Kingdom. Contact: Fiona Morris, Royal Society of Medicine, Medical Services, 1 Wimpole Street, London W1M 8AE, United Kingdom.

**THE SOCIETY FOR PUBLIC HEALTH EDUCATION (SOPHE) MIDYEAR CONFERENCE, "POLICY, POLITICS AND ADVOCACY: SETTING A HEALTH PROMOTION AGENDA FOR THE 1990s," June 14-16, 1990.** Will include programs involving community organization, policy interventions, coalition-building, legislative approaches, minority health, organizational change, economic issues, and advocacy for health promotion/disease prevention. Holiday Inn By The Bay, Portland, Maine. Contact: Larry Johnson, CHEP Program, Veterans Administration, Medical & Regional Office Center, Togus, ME 04330, 207/623-5744.

**THE SECOND INTERNATIONAL CONFERENCE ON SOCIAL WORK AND AIDS, "AIDS '90: THE SOCIAL WORK RESPONSE," June 16-19, 1990.** Cosponsored by the Schools of Social Work at San Jose State University, Tulane University, and Boston College. San Jose, California. Contact: Manuel Fimbres, San Jose State University, School of Social Work, 1 Washington Square, San Jose, CA 95192-0124, 408/924-5800.

**THE SECOND INTERNATIONAL HIV CONFERENCE, "COUNSELING, TESTING, AND EARLY CARE," June 18-19, 1990.** Sponsored by the American Medical Association. San Francisco, California. Contact: John Henning, Office of HIV/AIDS, 535 North Dearborn Street, Chicago, IL 60610, 312/645-4566.

**SIXTH INTERNATIONAL CONFERENCE ON AIDS, June 19-23, 1990.** Sponsored by the University of California San Francisco, the city and county of San Francisco, the World Health Organization, and the International AIDS Society. Contact: Paul Volberding, San Francisco General Hospital, San Francisco, CA 94110, 415/550-0880 or Conference Secretariat, 655 15th Street NW, Suite 300, Washington, DC 20005, 202/639-5179.