



Increasing Access to HIV/AIDS Prevention and Care in Communities of Color

Kentucky Report

Kentucky **Executive Summary and Major Findings**

Introduction

African Americans disproportionately bear the burden of the HIV/AIDS epidemic in the United States. The Centers for Disease Control and Prevention (CDC) estimates that African Americans account for 49 percent of new HIV/AIDS diagnoses annually in the United States, although they constitute a mere 12 percent of the overall population.¹ African American men are diagnosed with HIV/AIDS at eight times the rate of white men.² The rate of diagnosis for African American women is twenty-three times higher than that of white women.³ Among African American men, three behavioral risk factors account for 93 percent of transmissions: male-to-male sexual contact (48 percent), injection drug use (23 percent), and heterosexual contact (22 percent). Among African American women, two main risk behavior categories account for 98 percent of transmissions: heterosexual contact (74 percent) and injection drug use (24 percent).⁴ When compared with other racial and ethnic groups, African Americans with HIV/AIDS are less likely to have health insurance and are more likely to rely on public sources of insurance. Moreover, once diagnosed, African Americans tend to postpone care due to multiple competing interests, ranging from food to housing to employment issues.

Purpose/Objectives

Given the disproportionate impact of HIV/AIDS on African Americans nationwide, the National Alliance of State and Territorial AIDS Directors (NASTAD) set out to assess the various barriers to accessing prevention and care services for this population. Founded in 1992, NASTAD is a nonprofit national association of state health department HIV/AIDS program directors who have programmatic responsibility for administering HIV/AIDS health care, prevention, education, and supportive services programs funded by state and federal governments.

African Americans in Kentucky comprise thirty one percent (31 percent) of the reported cumulative HIV/AIDS cases but comprise only seven percent of the state's population. This disproportionate impact of the HIV/AIDS epidemic in the United States and particularly within rural southern states

¹ *HIV/AIDS Surveillance Report, 2005*. Vol. 17. Atlanta: US Department of Health and Human Services, CDC: 2006:1–46.

² Ibid.

³ Ibid.

⁴ Ibid.

provided the impetus for NASTAD and the Kentucky Department of Public Health (KDPH), through a cooperative agreement with the Office of Minority Health (OMH), to examine barriers to HIV care and prevention services encountered by African Americans living in Kentucky. With the intention of increasing access to HIV prevention and care services, NASTAD's project focused on bringing to light obstacles that African American individuals in Kentucky reported inhibit their entry into a continuum of HIV care.

The following objective served to guide the planning and intervention efforts for this project: Conduct focus groups with African Americans in Kentucky to share perspectives and obtain recommendations that would increase state health department knowledge of barriers and challenges faced in accessing HIV/AIDS prevention and care services.

Background

Health Disparities in Kentucky

Kentucky has a population of 4,206,074 people, 51 percent of whom are female; seven percent are African American; and 88 percent are younger than 65 years of age. The statewide median household income is \$37,369. Compared to the national average, Kentucky has four percent more individuals living below the federal poverty level than the national average and six percent more individuals with disabilities.⁵ Despite its demographic similarities to the national average, Kentucky is home to significant health disparities. Nearly 14 percent of Kentucky residents lack health insurance coverage.⁶

With regard to HIV/AIDS, Kentucky reported 4,453 cumulative AIDS cases and was ranked 34th in the nation with six individuals per 100,000 reported living with AIDS at the end of 2005.⁷ Black Kentuckians represent seven percent of the state's population but 38 percent of the persons living with HIV/AIDS. African American men comprise 27 percent of the HIV/AIDS cases in Kentucky, while African American women represent 11 percent of this total.⁸ African Americans in Kentucky are 8 times more likely to be infected with HIV/AIDS as whites.⁹

⁵ U.S. Census Bureau Data. Kentucky state fact sheet.

⁶ *Income, Poverty, and Health Insurance Coverage in the United States: 2005*. U.S. Census Bureau. Issued August 2006. pages 26-28.

⁷ *HIV/AIDS Semi-Annual Report: December 2006*. Kentucky Cabinet for Health and Family Services, Department for Public Health, HIV/AIDS Branch. Volume 6, Number 2. Issued December 31, 2006.

⁸ Ibid.

⁹ Ibid.

HIV/AIDS Prevention and Care Funding

In 2006, the Centers for Disease Control and Prevention (CDC) awarded the Kentucky Department for Public Health (KDPH) \$2,588,979 to conduct HIV/AIDS/STD prevention and surveillance activities across the state to high risk target populations, including African Americans.¹⁰ To coordinate the state's care and prevention efforts, KDPH convenes the Kentucky HIV/AIDS Planning and Advisory Council (KHPAC) to provide guidance to the Ryan White Part B services program. 56 local health departments and a myriad of community based organizations participate in targeted prevention-related activities including counseling and testing, training, targeted outreach and education, peer education training, and prevention case management with HIV-infected individuals.

Ryan White Program funding to Kentucky totaled \$11,218,508 in FY2005.¹¹ Additionally, Kentucky Department of Public Health (KDPH) distributed \$1,877,915 under the Housing Opportunities for Persons with AIDS (HOPWA) as well as \$2,615,018 from the Substance Abuse and Mental Health Services Administration.¹² These funds provide care, treatment (including medications), and social support services to individuals living with HIV/AIDS.

Methodology

This project sought to elucidate the various factors limiting access to prevention and care services for African Americans in Kentucky. The following methodology was designed to guide efforts in reaching the main objectives of this effort: 1) To allow African American individuals to share perspectives and recommendations on strengthening HIV/AIDS prevention and care in Kentucky; and 2) To identify gaps and barriers that individuals face in accessing HIV care and prevention. Both qualitative and quantitative methods were used for data collection.

A multi-layered approach was used in the coordination and planning for this project. NASTAD initially contacted the AIDS director for the Kentucky Department of Health to explain the objectives of the project and enlist her support. The AIDS director then designated a health department staff person to oversee local project coordination including recruitment for focus groups and dissemination of a survey to be completed by health department staff and contractors. Information regarding the project activities was also

¹⁰ Henry J. Kaiser Family Foundation, "HIV Funding Profiles," retrieved July 25, 2007.

¹¹ Ibid.

¹² Ibid.

relayed to the department's internal divisions as well as to the state planning bodies.

NASTAD conducted ten pre-planning conference calls with health department staff and representatives from Kentucky's community based organizations (CBOs) to introduce the project, discuss project components, and define roles and responsibilities.

Focus group participants were recruited through the Kentucky State Department for Public Health and local community-based organizations (CBOs) who disseminated information regarding the focus groups. The CBOs used a combination of letters, flyers, meeting announcements and word of mouth advertising to recruit participants. Two of the focus groups were at local CBO sites; one was conducted at a hotel conference room.

Focus Group Component

Focus Groups: Consumers

NASTAD staff conducted a total of three focus groups with consumers within the state of Kentucky from July 26 to August 1, 2007. The focus groups were designed to gather information on the challenges faced by African Americans regarding access to HIV prevention and care services. NASTAD staff in collaboration with the Kentucky Department of Public Health also developed a **Kentucky Participant Questionnaire/Demographic Instrument** (see appendix) in order to capture additional information about focus group participants.

Focus groups were conducted in the following Kentucky cities: Louisville, Cincinnati, and Paducah. These cities represented areas in the state with a disproportionately high HIV/AIDS incidence. There were a total of 19 participants (n=8 females, n=10 males and n=1 transgender-identified) in the focus groups. Although the majority of participants (n=18) self-identified as African American or Black, one participant identified themselves as multi-racial. Seven participants were aged between 35 - 44 years; 10 between 45 - 54 years and two 55 years or older. The recruitment strategy targeted African Americans living with HIV/AIDS both in care (HIV related care in the last 12 months), and out of care (no HIV related care in the last 12 months).

One NASTAD staff facilitator and one NASTAD staff recorder was assigned to each focus group. NASTAD staff facilitators were chosen based on their cultural competency and familiarity with the target population (all facilitators

were African American) and their experience conducting focus groups. Focus groups lasted approximately one and a half hours and the facilitators adhered to a standard set of questions as outlined in a **Consumer Focus Group Questions/ Discussion Guide** (see appendix). This guide was developed by NASTAD staff with guidance from the Kentucky Department of Health.

Prior to beginning each focus group, facilitators reviewed a confidentiality agreement with the group. At the conclusion of the focus group, participants were asked to complete a Kentucky participant questionnaire/ demographic form which provided anonymous individual demographics and general health status.

Description of Data Collection Instrument

The facilitators' Focus Group Guide was an adaptation of a similar instrument previously used for the project to interview focus group participants. The instrument was modified by NASTAD, Kentucky health department staff, and CBO staff to be more consistent with the target population. It consisted of 11 questions along with additional probing questions. The instrument was designed to address four broad areas of focus: General – living with HIV, HIV Care, HIV Stigma, and HIV Prevention.

Data Analyses Protocol

All focus group materials including background materials, notes taken by observers and notes taken by facilitators were compiled and analyzed by NASTAD staff. Responses were organized by repeating ideas including any information that may have emerged but was not based on a particular question asked. Repeating ideas were then organized into themes. These themes helped guide the conclusions and proposed recommendations.

Consumer Findings

Major themes that emerged through the analysis of consumer focus group data were based on the four major question areas asked and concentrated into the following four areas: case management and social services, medical care and care settings, stigma and status disclosure, and mental health and personal beliefs.

1. Case management and social services

Participants indicated that though case managers (care coordinators) play an advocate role for clients, more care coordinators are needed. The care coordinators also need to improve attitudes towards clients and improve

follow through. Some care coordinators need to be more interactive with African American clients and should discuss where and what services are available to the newly diagnosed.

2. *Medical care and care settings*

Many participants stated that they receive good care from all medical staff. Clinic staff addressed most care needs and pharmacists were instrumental in client care, medication and treatment adherence. Participants did have concern regarding confidentiality among clinic and support staff which can be a barrier to care if clients do not feel their confidentiality is safeguarded. Length of wait times for appointments and limited staff make it difficult for clients to access and stay in care. Participants suggested that more medical and social services be included at the same clinic location i.e. more “one-stop-shops” and that staff size be increased.

3. *Stigma and status disclosure*

The majority of participants identified reticence disclosing their HIV status due to stigma and discrimination from family, friends, neighbors, and employers. Participants also reported experiencing stigma and discrimination at social service agencies, in seeking and securing housing, and with dental care. Participants indicated that educating the community and care staff was the only way to decrease stigma.

4. *Mental health and personal beliefs*

Post diagnosis, many participants identified concerns of mental and emotional health. Some had come to a point of acceptance, while others were still struggling with the reality of their status. Participants expressed that going to support groups and meeting HIV positive advocates was a great source of support.

Question Focus	Positive Perspectives	Negative Perspectives
<p>Access and barriers to care</p> <ul style="list-style-type: none"> • Advocates and Access to Care • Staff-client Relationships • Addressing Unmet Need and Retention in 	<ul style="list-style-type: none"> ▪ <i>Peer advocates are very important to ensuring a client’s access into care;</i> ▪ <i>Care coordinators and case managers find time to help and there is good rapport;</i> ▪ <i>There are good relationships with physicians and infectious disease doctors; they also provide information on substance abuse and other</i> 	<ul style="list-style-type: none"> ▪ <i>Some care coordinators/case managers are not helpful, don’t care, don’t follow through and are not a good fit with the client. Case managers should be more active in client care and more accountable to the client;</i> ▪ <i>More case managers and peer advocates are needed;</i> ▪ <i>Clergy are not good</i>

Question Focus	Positive Perspectives	Negative Perspectives
<p>Care</p> <ul style="list-style-type: none"> • Barriers to Care 	<p><i>HIV related services;</i></p> <ul style="list-style-type: none"> ▪ <i>The pharmacists work closely with other care providers;</i> ▪ <i>The receptionists and front line staff show a lot of care and project a good atmosphere; and</i> ▪ <i>Clients report getting good care from nurses and phlebotomists.</i> ▪ <i>There is top notch care for veterans in the Veterans Administration (VA) system</i> 	<p><i>advocates for HIV positive clients;</i></p> <ul style="list-style-type: none"> ▪ <i>There should be some case managers and advocates who are also a member of their target group, e.g. youth, or gay men;</i> ▪ <i>Case managers should identify the priority needs of the client and address them first, recognizing that these needs may not always be specific to HIV/AIDS but can also include issues of food security, housing, etc.;</i> ▪ <i>The pharmacy works slowly sometimes;</i> ▪ <i>Appointments are spread out making it difficult to coordinate follow ups; the time between appointments should be shorter and more time should be allocated for appointments;</i> ▪ <i>Clients are frustrated about the time it takes to get Supplemental Security Income (SSI) related paperwork approved;</i> ▪ <i>More staff are needed;</i> ▪ <i>More privacy in the waiting area and front desk as sometimes staff discuss medical and care issues in the open;</i> ▪ <i>Doctors should have clinic visits in a shelter – the HIV positive homeless population is not being reached;</i> ▪ <i>There is a gap from diagnosis to seeking care; clients need someone to walk them through this process e.g.</i>

Question Focus	Positive Perspectives	Negative Perspectives
		<p><i>outreach workers, advocates, support networks;</i></p> <ul style="list-style-type: none"> ▪ <i>Transportation is provided only to doctor's visits, but not for other issues such as going to court and other social services;</i> ▪ <i>There is a lack of information for individuals who are newly diagnosed on where they can get care, education about HIV, and where support groups meet;</i> ▪ <i>Confidentiality in a small community is difficult; and</i> ▪ <i>There are few places to access dental care.</i>
<p>Living with HIV/AIDS in the community</p> <ul style="list-style-type: none"> • HIV Positive and African American • HIV Disclosure • HIV Attitudes 	<ul style="list-style-type: none"> ▪ <i>There are some support groups that provide important information and help clients through the disease process</i> ▪ <i>There are a handful of Black HIV positive advocates who reach out to empower others</i> 	<ul style="list-style-type: none"> ▪ <i>Stigma extends across all communities (Black and Latino, heterosexual, Lesbian, Gay, Bisexual and Transgender (LGBT));</i> ▪ <i>Clients report being afraid to share their HIV status with family or neighbors; most people with HIV do not disclose;</i> ▪ <i>The community is not informed and therefore have inaccurate attitudes about HIV and those infected;</i> ▪ <i>Living with HIV is complex and has multiple components such as mental and substance abuse issues;</i> ▪ <i>Denial and stigma come as a result of the community not being educated;</i> ▪ <i>HIV disclosure is difficult – it is hard to be honest in a small community where it is inevitable that once your status is disclosed to</i>

Question Focus	Positive Perspectives	Negative Perspectives
		<p><i>someone, confidentiality is not guaranteed;</i></p> <ul style="list-style-type: none"> ▪ <i>Being HIV positive is associated with being homosexual; and</i> ▪ <i>Settings where disclosure is especially difficult to do—churches, emergency rooms, place of employment, housing, dentist, beauty/barber shops and nail parlors.</i>
<p>HIV Prevention</p> <ul style="list-style-type: none"> • HIV Prevention Education and Health Information • Outreach and HIV Prevention 	<ul style="list-style-type: none"> ▪ <i>Participants provided the following as sources of HIV prevention information: health centers, clinics, VA, health fairs, health department, Oprah and even the community "grapevine" though this did not always provide accurate information.</i> 	<ul style="list-style-type: none"> ▪ <i>Do more outreach – take HIV prevention messages to the community;</i> ▪ <i>There needs to be more information put on the street;</i> ▪ <i>The messages need to go into the churches e.g., have sermons on HIV, preach about sex;</i> ▪ <i>Use more mass media/commercials on TV and radio, billboards;</i> ▪ <i>Use celebrity endorsement e.g. Magic Johnson, Sheryl Lee Ralph (Sometimes I cry performance);</i> ▪ <i>Need to increase education in schools to target the youth; and</i> ▪ <i>More condom distribution, mobile van services, and flyers.</i>

Consumer Focus Group Recommendations to the Kentucky Health Department

Listed below are specific recommendations from the focus group participants to the Kentucky Health Department on ways to address barriers and unmet needs.

- Provide the HIV positive community with more information on prevention and care services for HIV;
- The health department should take a leadership role in guiding CBOs and the community into action i.e., take the lead not a passive role;
- Put more focus on substance abuse issues related to HIV;
- HIV needs to be a greater concern for the African American community;
- There should be a more diverse representation in the health department staff as well as care coordinators and case managers; specifically more representation of men who have sex with men (MSM), individuals who identify as transgender, and Black staff members;
- The health department needs to advocate more on behalf of the community through more education, flyers, seminars, HIV education classes;
- Use “shock reality” messages as a way to reinforce the message to curtail people’s apathy to the seriousness of the epidemic; go back to messages that evoke a sense of fear about contracting HIV/AIDS; show visible effects of AIDS so people will start protecting themselves and applying prevention messages;
- Increase funding for outreach prevention efforts;
- Increase social marketing efforts particularly radio, TV, and billboards;
- Ensure that HIV/AIDS prevention messages and related public service announcements are not always played late at night, but rather during times when people are actually engaged, awake and watching;
- Implement mandatory routine testing;
- Mandatory testing of criminal offenders upon release;
- Increase access to care and treatment services by funding more services/ CBOs;
- Make staff of funded grantees accountable for client confidentiality especially in small, rural communities of the state.

Focus Group: Service Providers

NASTAD staff conducted a total of three focus groups with service providers within the state of Kentucky from July 26-August 1, 2007. The focus groups were designed to gather information on the challenges faced by African Americans regarding access to HIV prevention and care services.

Focus groups were conducted in the following Kentucky cities: Louisville, Cincinnati, and Paducah areas. These cities represented areas in the state with a disproportionately high HIV/AIDS incidence. Focus group participants were staff from the Kentucky State Department for Public Health and local

CBOs. The focus groups were conducted at the same site as the consumer groups, but at different and separate times; a local CBO served as the site for two groups; and one was conducted in a hotel conference room.

There were a total of 28 individuals representing agencies in the area which provide a variety of services to the community in multiple settings. Some of the services that agency representatives provide are medical, mental health, and case management services.

One NASTAD staff facilitator and one NASTAD staff recorder were assigned to each focus group. Focus groups lasted approximately one and a half hours and the facilitator adhered to a standard set of questions as outlined in a **Provider Focus Group Questions/ Discussion Guide** (see appendix). This guide was developed by NASTAD staff with guidance from the Kentucky Department of Health.

Description of Data Collection Instrument

The facilitators Focus Group Guide was an adaptation of the consumer instrument. The instrument was modified to better capture responses from service providers. It consisted of 11 questions along with additional probing questions. The instrument was designed to address four broad areas of focus: General – perceptions of living with HIV, HIV Care, Stigma and HIV Prevention.

Data Analyses Protocol

All focus group materials including background materials, notes taken by observers and notes taken by facilitators were compiled and analyzed by NASTAD staff. Responses were organized by repeating ideas including any information that may have emerged but was not based on a particular question asked. Repeating ideas were then organized into themes. These themes helped guide the conclusions and proposed recommendations.

Provider Findings

Major themes that emerged through the analysis of provider focus group data were based on the four major question areas asked and concentrated into the following three areas: access and barriers to care; living with HIV and stigma; and HIV prevention resources.

- 1. Access and barriers to care, specifically addressing advocates and access to care, staff-client relationships and addressing unmet need.*

Provider participants expressed that doctors and care coordinators worked closely with triaging clients to ensure that client needs were addressed based on priority and therefore improving access to care. Support networks and staff collaboration were key in assisting a client access, move through and remain in care.

2. *Living with HIV/AIDS in the community, specifically in relation to HIV positive and African American, HIV disclosure and attitudes to HIV.*

A resounding response from the provider participants was the issue of HIV stigma and client confidentiality in the African American community. Clients have a fear of disclosure due to perceptions and being ostracized from one’s support network – friends, family, housing and employment.

3. *HIV prevention strategies related to HIV prevention, education and health information, outreach and HIV prevention.*

Provider participants emphasized optimizing media sources as key in spreading and reinforcing HIV prevention messages. This could be done through targeted radio programs and television public service announcements.

Question Focus	Positive Perspectives	Negative Perspectives
<p>Access and barriers to care</p> <ul style="list-style-type: none"> • Advocates and Access to Care • Staff-client Relationships • Addressing Unmet Need and Retention in Care • Barriers to Care 	<ul style="list-style-type: none"> ▪ <i>Medical doctors work closely with clients and channel them into case management and other medical services;</i> ▪ <i>Good VA clinic;</i> ▪ <i>The Early Prevention Intervention Project channels clients into HIV education and support groups for newly diagnosed;</i> ▪ <i>There is a link between the local clinic and correctional facility;</i> ▪ <i>Some correctional facilities test and put positive inmates into care;</i> ▪ <i>There are LGBT support groups;</i> ▪ <i>Support groups are listed in the newspaper;</i> ▪ <i>Agencies make referrals with</i> 	<ul style="list-style-type: none"> ▪ <i>We need a triage system where needy patients have easy and immediate access to care;</i> ▪ <i>Some health providers are ignorant of the actual physical and mental disabilities with which HIV+ patients deal;</i> ▪ <i>Instances of breach of confidentiality;</i> ▪ <i>Staff lack cultural competency, basic knowledge of HIV, and skills to assist clients e.g. illiterate clients;</i> ▪ <i>We need to reach people where they are – go to where people are;</i> ▪ <i>There is a race climate in the local area that breeds separateness and establishes</i>

Question Focus	Positive Perspectives	Negative Perspectives
	<p><i>each other and they have Memoranda of Understanding/Agreements (MOU/As);</i></p> <ul style="list-style-type: none"> ▪ <i>Care coordinators assist clients with access to ADAP, transportation and other services;</i> ▪ <i>There is respect of clients by most providers;</i> ▪ <i>There is a team approach in managing a client's case;</i> ▪ <i>Service providers strive to offer enough time during appointments; and</i> ▪ <i>Friendly staff that make an effort to have a welcoming clinic and office environment.</i> 	<p><i>a place of mistrust, hence a barrier for some African American clients to access care;</i></p> <ul style="list-style-type: none"> ▪ <i>Need more funding African American and Latino programs;</i> ▪ <i>Better appointment scheduling to reduce time between appointments;</i> ▪ <i>Lack of comprehensive home visits;</i> ▪ <i>More education with African American women on empowering themselves; and</i> ▪ <i>General barriers – transportation, stable housing, staff shortage, inflexible work hours, stigma, childcare, lack of social support from family, churches and legal issues/ incarceration.</i>
<p>Living with HIV/AIDS in the community</p> <ul style="list-style-type: none"> • HIV Positive and African American • HIV Disclosure • HIV Attitudes 	<ul style="list-style-type: none"> ▪ <i>Veterans have the option of going out of town, away from the local area to access services.</i> 	<ul style="list-style-type: none"> ▪ <i>Clients feel like outcasts or pariahs and are not able to talk to family members; individuals are ostracized if they disclose;</i> ▪ <i>Stigma;</i> ▪ <i>Lack of education about HIV in the African American community;</i> ▪ <i>Fear of HIV positive parents that there is a threat of losing parental rights because of the perception of their ability to provide care;</i> ▪ <i>The reluctance in the African American community to address HIV/AIDS;</i> ▪ <i>Faith based organizations and the Black Church are not</i>

Question Focus	Positive Perspectives	Negative Perspectives
		<p><i>upfront and out there about the disease;</i></p> <ul style="list-style-type: none"> ▪ <i>HIV is still perceived as a "white gay man's disease" hence denial, homophobia and the "Down Low" syndrome;</i> ▪ <i>Fear of eviction by land lords;</i> ▪ <i>Perceived negative bedside manner by some practitioners, emergency room, dentists;</i> ▪ <i>Discrimination e.g. client denied admission into nursing home; and</i> ▪ <i>A fear losing their employment.</i>
<p>HIV Prevention</p> <ul style="list-style-type: none"> • HIV Prevention Education and Health Information • Outreach and HIV Prevention 	<ul style="list-style-type: none"> ▪ <i>Participants provided the following as sources of HIV prevention information: "the corner" – word of mouth, Momma, Grandma, prevention and case management programs, collaborative advisory groups and advocates, minority outreach groups, regional planning, point of entry – medical system and referral networks, health department, media – radio & TV, some church leaders, community based organizations.</i> 	<ul style="list-style-type: none"> ▪ <i>Media campaigns need to be fully utilized e.g. and have monthly radio programs with fresh captivating messages such as Radio One use of hip hop music;</i> ▪ <i>There is a lack of public service announcements and other social marketing to maintain momentum of prevention messaging;</i> ▪ <i>More mobile vans needed in the local community; and</i> ▪ <i>Church leaders are not involved.</i>

Recommendations to the Kentucky Health Department

Listed below are specific recommendations for consideration by the Kentucky Health Department that address barriers/unmet need as identified in focus groups of service providers and conference participants. These recommendations are neither exhaustive nor definitive; rather, they

represent a useful framework for planning and strengthening programming to address HIV/AIDS in communities in the state of Kentucky.

Recommendations from Focus Group Service Providers

- Testing and more testing towards early detection
- Make educational messages relevant to the community; community already has views of health disparities in the health department/ medical system.
- Identify leaders in the Church, local businesses and the community to help with prevention efforts.
- Need to bring messages that relate to the clients and mitigate already set perceptions/ community mindset/mistrust of the health system.
- More education of prevention efforts to general community and not only high risk groups. For example, through:
 - Schools
 - Churches
 - Community groups
 - Media
- Hire a full time nurse practitioner to do STD testing
- Make efforts to legalize needle exchange programs
- Rapid testing at the health department
- Eliminate testing fees
- Bring HIV testing under Prevention and not STD
- Social marketing – sponsor billboards, flyers, etc
- State HIV epidemiology needs to be widely disseminated
- Using children immunization programs as outreach
- Ensure that hospitals are giving out accurate information
- Reach out to the WIC Program and having HIV screening as part of the program
- Offer HIV education to employers and employees in the local community outside of the HIV community
- Set up a condom distribution campaign such as “Condom Man/ Woman” in the local community who people will feel comfortable talking to
- At health fairs:
 - Combine HIV testing booths with one doing blood pressure/ diabetes testing since people tend to steer way from the “HIV booth”
 - Hand out pre-packaged bags with condoms and testing information as health department staff walk around the health fair

Recommendations from conference participants at the 2007 African American and Hispanic Leadership Conference on HIV/AIDS, Lexington, KY – September 7, 2007

Group 1

- More programs to target youth
- Conduct additional local focus groups to capture working consumers (evening hours)
- Address systems/bureaucratic barriers (e.g. STD/Hepatitis program notification for minors, collaborations, etc.)
- More planning for transgender population in funding parameters/ requirements for targeted populations
- Finding ways to interlink existing programs to consumers, for example, through a comprehensive resource directory that includes faith-based initiatives
- More re-entry programs for incarcerated populations
- Prevention and education programs targeting senior citizens
- Encourage more African American advocates on the front lines; pass on influential messages - start through the underground and build up trust from there
- Address the issue of diversity in class systems
- Stop hiding behind stigma
- Use media outreach with adaptable messages from other similar communities
- Create incentives programs to encourage participation in conferences, meetings etc

Group 2

- Offer internships in care services to introduce future care staff to environment of care services and increase recruitment of students of color
- Develop new case management protocols/ guidelines that address needs of the community
- Train staff to interact with clients beyond cultural competency i.e., people skills
- Build programs based on community needs and not grant mandates; other social needs are more pressing than surveillance numbers and should be addressed
- Utilize incentives programs to educate and address client needs e.g., gas cards, gift certificates, food vouchers/ meals at conferences
- Local staff at CBOs should be from the community
- Need to address apathy within the health department system

- Need to address racial/ethnic health disparities such as socio-economic status and prioritize need and funding specific to communities with most need
- Utilize advisory groups and create statewide coalitions with community leaders such as church leaders, fraternities and sororities in venues such as college campuses and national recognition/testing days to create awareness and spread the HIV education message