

Howard University

Digital Howard @ Howard University

National Minority AIDS Education and Training
Center Publications

National Minority AIDS Education and Training
Center

1-1-2002

BESAFE - LATINO AMERICAN MODEL BOOK

NMAETC Staff

Follow this and additional works at: https://dh.howard.edu/nmaetc_pubs

Recommended Citation

Staff, NMAETC, "BESAFE - LATINO AMERICAN MODEL BOOK" (2002). *National Minority AIDS Education and Training Center Publications*. 2.

https://dh.howard.edu/nmaetc_pubs/2

This Book is brought to you for free and open access by the National Minority AIDS Education and Training Center at Digital Howard @ Howard University. It has been accepted for inclusion in National Minority AIDS Education and Training Center Publications by an authorized administrator of Digital Howard @ Howard University. For more information, please contact digitalservices@howard.edu.

BE SAFE

A Cultural Competency Model for Latinos

National Minority AIDS Education and Training Center





BE SAFE

A Cultural Competency Model for Latinos



**National Minority AIDS Education
and Training Center
at Howard University
Washington, DC**

In Collaboration With

The University of Texas Health Science Center
San Antonio, Texas

and

National Council of La Raza
Washington, DC

Britt Rios-Ellis, PhD
Editor

Noelle Fritz, BA
Editor

Antonio Duran, BS

Rocio A. Leon, BS



Contributors

Fred Dominguez, MD, MPH, Charles R. Drew University of Medicine and Science

Antonio Duran, BS, LVN, The University of Texas Health Science Center at San Antonio

Noelle Fritz, BA, The University of Texas Health Science Center at San Antonio

Rocio A. Leon, BS, National Council of La Raza, Institute for Hispanic Health

Claudia Marquez, MSW, Mosaica, The Center for Nonprofit Development and Pluralism

Claudia Martorell, MD, MPH, Harvard Medical School

Martha Medrano, MD, MPH, Medical Hispanic Center of Excellence, The University of Texas Health Science Center at San Antonio

Britt Rios-Ellis, PhD, California State University, Long Beach, Department of Health Sciences and National Council of La Raza, Institute for Hispanic Health

Lydia Santiago, PhD, University of Puerto Rico, Graduate School of Public Health

Carlos Ugarte, MSPH, National Council of La Raza, Institute for Hispanic Health



Contents

Contributors	ii
Preface	iv
Acknowledgements	v
Introduction	1
Barriers to Care	13
Ethics	31
Sensitivity of the Provider	40
Assessment	47
Facts	55
Encounters	72
Conclusion	86
Appendix: Case Scenarios	88
Glossary	91

Preface

The National Minority AIDS Education and Training Center (NMAETC) is a collaborative network of health experts funded by the Health Resources and Services Administration (HRSA) to provide capacity building to agencies and providers that treat minority patients afflicted with the human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS). Capacity building focuses on strengthening organizational infrastructure and improving the delivery of HIV primary care services at clinics by using collaborative approaches, best care practices, and culturally appropriate clinical models. The ultimate goal of capacity building is to improve HIV/AIDS patient outcomes.

NMAETC is headquartered at Howard University in Washington, DC, with additional sites at The University of Texas Health Science Center at San Antonio, Charles R. Drew University of Medicine and Science, Meharry Medical College, Xavier University, Navajo AIDS Network, Inc., and the University of Maryland. The mission of NMAETC is to improve HIV patient outcomes by increasing the core competencies of clinics and providers. To accomplish this mission, NMAETC works to increase: (1) the number and effectiveness of HIV/AIDS clinical and support services; (2) the numbers and frequency of HIV/AIDS patients treated; (3) the cultural competence of providers; and (4) the number of qualified HIV specialists. Included in this effort is a capacity building preceptorship program of HIV/AIDS specialists to train and educate health care providers who treat minority patients with HIV infection and AIDS. The preceptorship program includes hands-on education and training sessions in HIV/AIDS disease management. With the aim to develop and improve clinical provider skills under the guidance of an experienced faculty member the program results in a professional relationship that provides consultations, co-management, and other related support.

Recent statistics show that HIV is disproportionately affecting minority communities in the United States, particularly African Americans and Latinos. In response to these disparities, NMAETC, in collaboration with The University of Texas Health Science Center at San Antonio and the National Council of La Raza, has developed a Latino cultural competency model to be used by health care providers who treat Latino patients with HIV/AIDS. The mnemonic, BE SAFE, is a framework that uses culturally pluralistic content and perspectives based on the following six core elements: (1) Barriers to Care, (2) Ethics, (3) Sensitivity of the Provider, (4) Assessment, (5) Facts, (6) Encounters. This BE SAFE book will discuss each of these six core elements in order to provide health care professionals with a culturally relevant framework that will assist them in providing primary health care services to Latinos infected with, or affected by, HIV/AIDS.

The BE SAFE Latino model is intended to familiarize providers with a basic understanding of the Latino patient, and his or her cultural background and beliefs. It is our hope that this book will pave the way for culturally responsive approaches to health care delivery.

Acknowledgements

We thank our colleagues for their contribution and support of this project.

NMAETC Staff

The University of Texas Health Science Center at San Antonio

California State University, Long Beach, Department of Health Science

National Council of La Raza, Institute for Hispanic Health

Health Resources and Services Administration

National Association of AIDS Education and Training Centers

Terence Doran, MD, PhD, The University of Texas Health Science Center
at San

Antonio, Department of Pediatrics

Victor German, MD, PhD, The University of Texas Health Science Center
at San

Antonio, Department of Pediatrics

James Moa, EdD, MHA, MS Ed, The University of Texas Health Science
Center at San Antonio, Department of Pediatrics

Anthony Scott, PhD, The University of Texas Health Science Center at
San Antonio, Department of Pediatrics

Finally, we recognize the health care providers who care and treat Latino patients infected with HIV/AIDS. Your efforts and your commitment to culturally competent patient care are commendable. We hope this publication will be of great assistance to you in your efforts to better understand the needs of your Latino patient population.

Introduction

Current disparities in health care services are negatively affecting specific minority groups in this country. Cultural competency is a tool that can be used by health care providers in decreasing these health disparities and in providing more effective care to minority clients. Currently, HIV/AIDS is drastically affecting the Latino community. According to the Centers for Disease Control and Prevention (CDC), although the Latinos in 2001 formed only 13.2% of the U.S. population, they accounted for one-fifth of all AIDS cases. From 1999 through 2003, AIDS cases among Latinos increased by 26.2% (CDC, 2003b).

Many cultural, socioeconomic, and environmental factors have an impact on the Latino population infected with, or affected by HIV/AIDS. By becoming aware of these factors and responding to them accordingly, health care providers can decrease current health disparities affecting Latinos with and at risk for, HIV/AIDS. Providers can use this awareness to increase the effectiveness of their patient encounters and facilitate an improvement in the health outcomes of their Latino patients. This in turn can significantly help to meet the increasing needs of Latinos infected and affected by HIV/AIDS, and over the next several years may also help reduce the number of HIV cases among the Latino population.

Culture and Cultural Competency

Culture is a concept that refers to integrated patterns of human knowledge, beliefs, and behaviors that depend on human capacity for learning and transmitting knowledge to succeeding generations. Culture also relates to customary beliefs, shared attitudes, values, goals, practices, social forms, and material traits of a racial, religious, or social group (Office of Minority Health [OMH], 2001). To be “culturally competent” means to be capable of working effectively in cross-cultural situations. Cultural competency in health care requires congruent behaviors, attitudes, and policies targeted at meeting the patient’s needs (Cross, Bazron, Dennis, & Isaacs, 1991). Wong and Chapman (2003) identified several core capacities needed for cultural competency, including self-awareness, effective communication, cultural desire, humility, cultural knowledge, and dynamics of difference. In addition, Walton (2003) suggests that culturally competent health care providers incorporate mutual respect, empathy, and flexibility in their work.

Health care is a cultural construct due to the fact that beliefs about health, disease, and perceived causes of sickness stem, in part, from an individual's culture. Therefore, to be effective, health care services should be respectful of, and responsive to, cultural and linguistic needs (OMH, 2001). The values, needs, and preferences of the patient should always be taken into consideration, and health care workers must strive to overcome barriers that prevent the patient from receiving optimal care. Culturally competent health care providers are necessary for several reasons. Most importantly, culturally they are needed to help eliminate health disparities affecting different racial and ethnic groups in the United States. Minority populations are disproportionately affected by major diseases such as HIV infection and AIDS and also face substantial obstacles when seeking care and treatment. Cultural competency is imperative to respond to current demographic trends, improve patient outcomes, and increase the overall quality of care (National Center for Cultural Competence, 2004). Moreover, the culturally competent health care provider will develop the needed skills and interpersonal capacity to better respond to a diverse patient population and changing world, and may experience a resulting increase in provider satisfaction.

To be effective, health care services should be respectful of, and responsive to, cultural and linguistic needs.

The Latino Population

To furnish the Latino community with competent HIV/AIDS-related care, health care providers must first become familiar with the rich diversity of the Latino population. An understanding of Latino history in the United States, and the various terms used to describe what is now the largest minority population in the United States, is essential. Latino ethnicity is comprised of a diverse background of individuals of indigenous, African, Anglo, European, Asian, and Middle Eastern descent.

While "Hispanic" has been the official descriptive term adopted by the U.S. government since the 1970s, many Latinos believe this term more accurately describes those from the Iberian Peninsula in Spain and therefore does not give adequate credit to indigenous roots of Latin America. For this reason, many individuals from Latin America and the Caribbean believe that the term "Hispanic" does not adequately describe their backgrounds and prefer to refer to themselves with the derivatives of their countries of origin. Others prefer the term "Latino" or "Latina," as it does acknowledge the indigenous contributions from Latin America. However, the term "Latino/a"

does not adequately identify the many individuals of Caribbean descent, who often are called *Caribeños*. In addition, a substantial number of Latinos involved in the historical struggle for civil rights in the Southwestern United States often self-identify as Chicano. Surveys conducted within the United States have revealed that the majority of Latinos prefer to identify themselves by their national origin, even in cases in which their national origin is not their place of birth (Falcón, Aguirre-Molina, & Molina, 2001).

It is essential for the provider to recognize that each patient of Latino or Caribbean descent should be provided the opportunity to discuss or report his or her ethnic background as desired. Providers need to be aware that as much as an individual's ethnicity may reveal, it is merely a small piece of patient information, given the cultural contexts of what it means to be of Latino or Caribbean descent in the United States.

In 2000, a full decade before predicted, Latinos became the largest minority group in the United States (U.S. Census Bureau, 2001). The most conservative estimates recognize that Latinos now comprise 13.2% of the U.S. population, with as much as 10% of this number unreported due to low participation in the U.S. Census process and redistricting of highly populated Latino areas. The Latino population is primarily made up of those of Mexican descent (66.1%), followed by Central and South Americans (14.5%), Puerto Ricans (9%), Cubans (4%), and other Latinos (6.4%) (Falcón et al., 2001). Although Mexicans, Mexican Americans, and Chicanos comprise the largest group of Latinos in the United States, Central and South Americans—comprised primarily of Salvadorans, Guatemalans, and Colombians—are the fastest growing subpopulation. Additional groups of Caribbean Latinos aside from Cubans and Puerto Ricans (e.g., Dominicans) are often merged in this category despite distinct sociopolitical histories and cultures. Additionally, several groups of non-Spanish-speaking indigenous groups from Latin America have established themselves in the United States, many of whom do not readily identify as Latino or Hispanic. These groups include, among others, the Mixtec-Zapotec Indians from the southern regions of Mexico; Guatemalan and Mexican Mayan Indians who speak Mayan; Paraguayan immigrants who speak Guarani; and Brazilian immigrants who speak Portuguese.

Differences in immigration experiences, history, rural or urban origin, and cultural norms and expressions are common throughout Latino subpopulations and are definitive factors in shaping HIV-related knowledge and risk in the United States. Latinos are a group with

distinct ethnic characteristics; acculturation levels; migration patterns; generational status; and occupational, demographic, and language profiles. These differences in historical, social, economic, and political factors may result in direct health care status and delivery implications (Kaiser Permanente National Diversity Council and the Kaiser Permanente National Diversity Department, 2001). It is imperative that the provider avoids stereotyping the Latino patient at all costs and bases diagnosis and treatment approach on a thorough assessment of the patient's medical needs and his or her background.

HIV/AIDS among Latinos in the United States

Overall, the number of AIDS cases diagnosed in the United States increased each year from 1986 to 1994. During the 1990s, important new advances were made in the treatment of HIV/AIDS. These medical advances, coupled with prevention efforts, led to a decline in the number of new AIDS cases and AIDS-related deaths. However, not all racial and ethnic groups benefited at the same rate. AIDS cases among Latinos increased by 130% between 1993 and 2001, while Whites experienced a 68% increase (CDC, 2001).* HIV/AIDS is one of the fastest growing infectious diseases in the Latino population, and Latinos are the fastest growing group with new HIV infections in the United States (CDC, 2003a). From 1999 to 2002, rates of new infection among Latinos increased by 26.2%. Of the 29 States included in the Centers for Disease Control and Prevention's HIV/AIDS Surveillance Report, data on HIV infection are unavailable from 7 of the top 10 States known to have the most Latino AIDS cases, including Texas and California.

In 2001, more than 70% of AIDS cases diagnosed in the United States were among minorities. The proportional distribution of AIDS cases among racial and ethnic groups has shifted since the beginning of the epidemic with an increase in proportion among Latinos and African Americans. For example, in 2001, 19% of AIDS cases were among Latinos, who represented 13.2% of the population (CDC, 2001; U.S. Census Bureau, 2000). Latinos also account for 19% of the reported 40,000 new HIV infections that occur in the U.S. each year, with the caveat that many of the States with the highest Latino populations have not yet published HIV data by race and ethnicity (CDC, 2002).

***Note:** In all instances in this book where Whites are discussed in comparison to Latinos, the term "Whites" refers to non-Latino Whites. _EDs.

Why is Cultural Competence important when working with Patients with HIV/AIDS?

The HIV/AIDS epidemic has principally affected specific social and racial/ethnic groups that have already experienced discrimination and socioeconomic disparities within our society. Health care providers' ideas, perceptions, and images of these populations affect expectations of patient-provider relationships. Stereotypes and prejudices can create multiple barriers to available resources and can result in the obstruction of adequate medical services for patients seeking care.

Model Development

NMAETC developed a unique model for African Americans infected with HIV by using the methods based on Dr. Josepha Campinha-Bacote's (1998) model, "The Process of Cultural Competence in the Delivery of Healthcare Services." NMAETC found the BE SAFE model to be very effective in addressing cultural competency for health care professionals who treat African-American patients infected with, or affected by, HIV/AIDS. A broad based coalition of experts thus decided that the BE SAFE model would be equally effective for providers who care for HIV/AIDS-infected and affected Latino patients. The Latino BE SAFE project endeavor was agreed on in August of 2003 at an NMAETC meeting convened in Washington, D.C. At this meeting a distinguished panel of more than 20 Latino and Latino-sensitive professionals came together to brainstorm on issues that needed to be addressed, and adapted, the Latino BE SAFE model. The panel of professionals included physicians, pharmacists, nurses, dentists, professors, researchers, administrators, consumers, and other experts with extensive experience in HIV/AIDS care and prevention among Latinos. The panel incorporated suggestions and thoughts from individuals of Mexican, Central and South American, Puerto Rican, Cuban, and other Caribbean descent. Members of the expert panel began work on the Latino BE SAFE model by conducting extensive reviews of the literature, and by committing to writing assignments for each of the six chapters based on the ideas that were generated in the 2-day brainstorming session. Latino experts and consumers reviewed each of the chapters, and feedback was provided to the various authors. The final outcome is a collaboration of writings from a variety of experienced professionals that can be used as an effective tool for developing cultural competency among health care providers serving the Latinos infected with, or affected by, HIV/AIDS.

The Latino BE SAFE Model

The Latino BE SAFE model addresses six culturally relevant topics that providers need to be cognizant of when caring for Latino patients. The acronym BE SAFE is used to represent the topics—Barriers to Care, Ethics, Sensitivity of the Provider, Assessment, Facts, and Encounters. Information contained in these chapters will assist health care professionals in treating Latino HIV/AIDS patients in a culturally relevant context. Presented below is a brief summary of each of the six chapters.

Barriers to Care

Barriers to care are real or perceived gaps to receiving or providing quality health care. This chapter outlines some of the most pertinent obstacles to care faced today by Latino patients with HIV/AIDS. These include linguistic issues, access to care and HIV testing, constructs of culture and gender, the stigma associated with HIV-positive status within the Latino community, and biases of health care professionals.

Language barriers can pose serious communication problems between health care providers and patients. Research suggests that English-speaking Latinos are afforded more benefits when seeking health care as compared to non-English-speaking Latinos (Solis, Marks, Garcia, & Shelton, 1990). Another major barrier to care for Latinos in the United States is lack of health insurance. Latinos are more likely than any other racial or ethnic minority in the United States to be uninsured or underinsured, and are less likely to use health services when available (Carrillo, Treviño, Betancourt, & Coustasse, 2001). Lack of insurance and underinsurance derive from a number of different factors including low socioeconomic status and a lack of legal documentation in the United States. The aforementioned factors also serve as independent barriers to care for HIV-positive Latinos. In addition, cultural expectations regarding gender roles can obstruct communication and access to care. For example, *marianismo* (the traditional gender role of the Latina) may contribute to a Latina patient's embarrassment in discussing sexual matters with a health care provider to the extent that care is impeded, just as *machismo* (the traditional gender role of the male Latino) may hinder a Latino male with an HIV diagnosis from seeking care or treatment.

Cultural issues related to *fatalismo* (a sense of fatalism) and *curanderismo* (using folk healers to cure illnesses) may also cause Latino patients to avoid seeking services from health care providers that practice standard Western medicine. The association between HIV/AIDS

BE SAFE MODEL

This framework comprises six core elements:

Barriers to care—real or perceived gaps to receiving or providing quality health care.

Ethics—a set of principles used to determine "right" or "wrong" behavior.

Sensitivity—cultural awareness and sensitivity on the part of the provider.

Assessment—ability to collect data in the context of the patient's culture.

Facts—understanding of patients' cultural beliefs and values, as well as awareness of health disparities and biological variations in HIV/AIDS.

Encounters—awareness of cultural norms related to Latino verbal and nonverbal communication.

and sexual promiscuity, drug use, and homosexuality often causes HIV-positive Latinos to be stigmatized by their community. Due to the Latino community's dependence on family for help and support (*familismo*), this stigmatization can be even more difficult to endure. HIV-positive Latinos may refuse to seek treatment for fear that others may discover their HIV/AIDS status and reject them. Some health care professionals may demonstrate a negative bias toward Latino patients, which often stems from a lack of knowledge about or experience with Latinos. Discriminatory attitudes and practices can result in negative health care outcomes and act as serious barriers to care.

It is imperative for health care providers to avoid prejudgments, prejudices, and stereotypes when interacting with Latino patients infected with, or affected by, HIV/AIDS. Negative experiences with biased health care providers can cause Latino patients to feel unwelcome and can result in decreased adherence to treatment and/or a reluctance to return for follow-up visits. It is essential that health care professionals become aware of the barriers to care that Latino patients face and actively explore possibilities for removing or overcoming these obstacles.

Ethics

Ethics or “moral philosophy” generally refers to a set of principles that are used to determine “right” or “wrong” behavior. Cultural competency aims to remove cultural barriers to care and to ultimately eliminate health disparities (Paasche-Orlow, 2004). Thus, ethics is a key component of cultural competency because the provider has to accept that cultural competency is the “right” thing to do before being able to commit fully to this process. Providers should make a conscientious effort to be culturally competent when dealing with Latino patients. Being aware of cultural biases the provider may hold, making serious attempts to eliminate such biases, and ensuring that cultural differences between the provider and patient are not resulting in negative consequences for the patient are all important aspects of culturally competent care. This chapter discusses four major guiding ethical principles for health care settings: (1) autonomy, (2) beneficence, (3) non-maleficence, and (4) justice, and applies them to provider interactions with Latino HIV/AIDS patients. Issues of patient confidentiality, partner notification, risks to health care workers, risks to patients, and clinical research are also addressed in this chapter.

Sensitivity of the Provider

Cultural competence requires that the health care provider have cultural awareness and sensitivity. Providers must be sensitive to their own cultural beliefs and values in addition to those of their patients in order to ensure successful communication and effective patient outcomes. Being aware of one's own cultural values can help providers avoid ethnocentrism and minimize problems related to cultural differences between patients and providers.

When caring for Latino patients infected with, or affected by, HIV/AIDS, provider sensitivity to language differences that may have an impact on communication is of paramount importance. Interpreters and bilingual written materials can be beneficial but should never serve as substitutes for an attentive provider who demonstrates concern and respect for his or her patients. Providers should be sensitive to language needs and also be cognizant of the literacy levels of their patients to guarantee that information is conveyed in the best possible manner. In addition, providers should be sensitive to the diversity of the Latino population and should avoid making broad generalizations or stereotypes about all Latinos. Latino subpopulations can have extremely different cultural mores and may be offended by provider assumptions made solely on the basis of race or ethnicity.

Sensitivity to the amount of exposure a Latino patient has had to health care in the United States can also have a positive impact on the patient-provider relationship. A provider who is aware of the standards of care that the patient has previously had can more easily help transition the Latino patient into the norms of Western health care. This chapter concludes with a self-assessment model that providers can use to evaluate personal levels of cultural sensitivity.

Assessment

Cultural assessment is defined as the ability of health care professionals to collect relevant data regarding the patient's presenting problems and health history in the context of the patient's culture (Campinha-Bacote, 1998). Cultural assessments can facilitate a provider's understanding of a patient's culture and this, in turn, can directly affect positive patient outcomes. Health care providers who are attentive to their patient's cultural beliefs and values have patients who are more likely to adhere to treatment regimens and return for follow-up visits. It is important for providers to conduct assessments in a culturally sensitive manner and with a nonjudgmental attitude.

While conducting the cultural assessment, providers may discover that their Latino patient holds cultural beliefs that are contrary to their own. During the cultural assessment, providers may also discover that their patient participates in behaviors or ritualistic events that are potentially objectionable or even shocking; it is important for the provider to demonstrate an interest in what the patient is saying and to refrain from reacting in a condemnatory manner. This chapter contains a variety of different tools and models that may be used by health care providers to conduct cultural assessments on their patients.

Facts

In order to provide culturally competent health care to Latino HIV-positive and AIDS patients, providers should have some level of understanding of their patients' cultural beliefs and values, as well as a basic awareness of the health disparities and biological variations in the manifestation of HIV/AIDS among Latino patients. Latinos are a very diverse population and no provider is expected to be an expert on the variety of Latino cultures; however, it is advantageous for providers to be aware of general cultural influences that may apply to the majority of their Latino patients. Important Latino beliefs and values that are covered in this chapter include fatalismo, *familismo*, *simpatia*, *confianza*, *respeto*, *marianismo*, and *machismo*. This chapter also offers an in-depth discussion of folk medicine practices within the Latino community. Latino patients with HIV/AIDS often seek out traditional folk healers for nonstandard treatment with which they may feel more comfortable. Providers should be aware that folk medicine treatment practices are usually harmless and can be psychologically beneficial to the patient.

Providers should be familiar with variance in manifestation of HIV and AIDS and treatment disparities among Latino patients. The implications of these disparities on a patient's attitude can be significant and can negatively affect help-seeking behaviors and patient perceptions of the health care system. Clinical health care providers serving the needs of Latino patients infected with HIV can benefit from learning more about HIV subtypes, tuberculosis infection in HIV/AIDS patients, HIV RNA levels and CD4 counts, genetic variations in susceptibility and response to HIV, and various opportunistic infections that disproportionately affect Latinos.

Encounters

To ensure effective encounters with Latino HIV/AIDS patients, providers should be aware of cultural norms related to verbal and non-verbal communication among the Latino population. This chapter addresses eye contact, facial expressions, gestures, touch, voice intonation, the use of proper titles, and the correct utilization of interpreters. Communication is the most critical aspect of the encounter between a Latino patient and a provider. In order to successfully communicate with a patient from a different culture, the provider must be familiar with, and able to address and respond to, the patient's cultural expectations. Another important aspect of the patient-provider encounter is the collection of the patient's background information and current health problems. Due to their impact on a patient's health, background and cultural information are an essential part of the data every provider should collect.

Chong (2002) developed the GREET model to help health care providers characterize their Latino patients. This model presents the opportunity for providers to collect necessary cultural and background information while simultaneously allowing for the demonstration of interest in the lives of their Latino patients, thus enabling the establishment of *confianza* (trust). The GREET acronym stands for Generation, Reasons for Immigrating to the United States, Extended or Nuclear Family, Ethnic Behavior, and Time Living in the United States. Additionally, this chapter includes culturally guided suggestions on how to interview the Latino patient and how to collect the patient's clinical history. This information can guide health care providers through their initial encounters with Latino patients and make both the patient and the provider feel more at ease. After a substantial number of encounters with Latino patients, a provider's cultural skills should improve and effective cross-cultural interactions facilitated.

Conclusion

Effectively treating the Latino HIV/AIDS patient requires a commitment to culturally competent care. Culturally competent care will aid in the elimination of current health disparities and increase positive patient outcomes. The information provided in the Latino BE SAFE model can be used as a guide for health care providers who wish to increase their knowledge about the Latino culture and issues facing Latino patients infected with, or affected by, HIV/AIDS. The Latino BE SAFE model can serve as an effective tool to increase the capacity of health care providers to treat Latino patients with HIV/AIDS.

While it is good to learn some specifics about the Latino culture, health care providers should remember that the Latino population is very diverse. Providers must be cautious of stereotyping Latino patients and should remember that individual experiences will result on each patient having his or her own unique, idiosyncratic culture. Providers who are committed to providing culturally competent care will strive to maintain an open and understanding attitude toward their patients' cultural beliefs, values, and backgrounds, and will make efforts to treat each and every Latino patient with the respect they deserve. The process of “becoming” culturally competent is a continual learning progression, and for this reason, each patient-provider interaction should be viewed as an opportunity for increased learning.

References

- Campinha-Bacote, J. (1998). *The process of cultural competence in the delivery of healthcare services: A culturally competent model of care* (3rd ed.). Cincinnati, OH: Transcultural C.A.R.E. Associates.
- Carrillo, J.E., Treviño, F.M., Betancourt, J.R., & Coustasse, A. (2001). Latino access to health care: The role of insurance, managed care, and institutional barriers. In M. Aguirre-Molina, C. Molina, & R. Zambrana (Eds.), *Health issues in the Latino community* (pp. 55-73). San Francisco: Jossey Bass Publishers.
- Centers for Disease Control and Prevention. (2001). *HIV/AIDS surveillance report, year end edition, 13(2)*, 1-44.
- Centers for Diseases Control and Prevention. (2002). *HIV/AIDS update: A glance at the epidemic*.
- Centers for Diseases Control and Prevention. (2003a). *HIV/AIDS surveillance supplemental report, 9(2)*.
- Centers for Disease Control and Prevention. (2003 b). Increases in HIV diagnoses—29 States, 1999-2002. *MMWR*, 52(47), 1145-8.
- Chong, N. (2002). *The Latino patient: A cultural guide for health care providers*. Yarmouth, ME: Intercultural Press.
- Cross, T. L., Bazron, B.J., Dennis, K.W., & Isaacs, M.R. (1991). *Towards a culturally competent system of care*. (Vol. 1). Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center.
- Falcón, A., Aguirre-Molina, M., & Molina, C. (2001). Latino health policy: Beyond demographic determinism. In M. Aguirre-Molina, C. Molina, &

R. Zambrana (Eds.), *Health issues in the Latino community* (pp. 3-22). San Francisco: Jossey Bass Publishers.

Kaiser Permanente National Diversity Council and the Kaiser Permanente National Diversity Department. (2001). *A provider's handbook on culturally competent care: Latino population* (2nd ed.).

National Center for Cultural Competence. (2002). *A guide to planning and implementing cultural competence organizational self-assessment*. Georgetown University Child Development Center. <http://gucchd.georgetown.edu/nccc>

Office of Minority Health. (2001). *National standards for culturally and linguistically appropriate services in health care: Final report* (pp. 3-131). Washington, DC: U.S. Department of Health and Human Services.

Paasche-Orlow, M. (2004). The ethics of cultural competence. *Academic Medicine*, 79(4), 347-350.

Solis, J.M., Marks, G., Garcia, M., & Shelton, D. (1990). Acculturation, access to care and use of preventive services by Hispanics: Findings from the HHANES, 1982-84. *American Journal of Public Health*, 80(Suppl. 12), 11-19.

U.S. Census Bureau. (2000). Summary File 3 (SF-3)—Sample Data.

U.S. Census Bureau. (2001). Current population survey, PGR-4.

Walton, S. (2003, October). *Cultural competence and leadership development*. Puerto Rico Public Health Leadership Institute Conference. Puerto Rico.

Wong, E.Y., & Chapman, S. (2003, June). Basic concepts, definitions and a framework for cultural competence. *Cultural competency in women's health: Training faculty to teach about providing culturally competent care for minority and underserved women*. Boston, MA: Harvard Medical School's Center of Excellence in Women's Health.

Barriers to Care

Latinos attempting to access HIV-related care and prevention often encounter multiple obstacles. According to the Centers for Disease Control and Prevention (CDC), Latinos represent approximately 13% of the population, but account for 20% of all AIDS cases within the United States (2002). The incidence rate of AIDS among Latinos is more than three times higher than the rate for Whites, demonstrating that AIDS is having a devastating effect on the Latino community. The AIDS case rate for Latino men in 2001 was more than three times that of White men and among Latinas, the AIDS case rate was more than five times the rate for White women (Kaiser Family Foundation, 2003). Overall, women comprise a growing share of new AIDS cases reported each year, a trend also seen in the Latino population. In 2001, Latinas represented 23% of new AIDS cases reported among all Latinos (Kaiser Family Foundation, 2003). Among Latino males with AIDS, the majority contracted HIV by having sex with other males (48%) or by injection drug use (IDU) (29%), with an increasing percentage infected through heterosexual contact (16%) (CDC, 2001). Among Latinas with AIDS, 65% were infected through heterosexual contact, and 32% through IDU (CDC, 2001). While one's race or ethnicity does not result in an increased risk for contracting HIV, there are underlying social and economic issues (such as cultural constructs, English language proficiency, literacy levels, poverty, and limited access to health care) that can specifically affect particular ethnic groups, thus, making them more at risk for becoming infected with HIV. These social and economic issues often result in an increased risk of infection, in addition to serving as significant barriers to care for Latino populations once they have contracted the virus. Moreover, Latinos report competing needs and barriers to health care that often inhibit access to HIV-related care.

Barriers to care are real or perceived gaps to receiving or providing quality health care (National Minority AIDS Education and Training Center, 2002). Several major barriers to care for the Latino population include linguistic issues, access to care and HIV testing obstacles, constructs of culture and gender, the stigma associated with HIV-positive status within the Latino community, and biases of health care professionals. Inasmuch as Latinos typically rely on community-based organizations and clinical providers, efforts to ensure adequate and appropriate HIV-related care for Latino patients must be addressed using effective and culturally competent systems to account for the previously discussed barriers to care (National Alliance of State and Territorial AIDS Directors, 2003).

Linguistic Issues

The growing ethnic and cultural diversity of the U.S. population underscores the need to ensure that providers are culturally competent in order to reduce racial and ethnic disparities in health care (Brach & Frasier, 2002). Some researchers state that limited ability to speak English among Spanish or indigenous speaking Latinos dissuades them from seeking care to the same degree as a lack of health insurance (Derose & Baker, 2000). Solis, Marks, Garcia, and Shelton (1990) analyzed the effect of language on screening practices and found that English-speaking Latinos access more preventive services than non-English-speaking Latinos. One key indicator of the level of acculturation of a Latino patient is his or her use of language in various contexts (Marin & Gamba, 1996). In many Latino communities, even among those with high levels of English proficiency, Spanish is often the preferred language. For example, in Colorado, while 72% of Latinos report that they speak English well, Spanish is used more often at home or in social situations (Colorado AIDS Education and Training Center, 2003). Even when Latinos are bilingual in Spanish and English, when seeking health care, it is more likely, Spanish may be the preferred language of communication.

Furthermore, providers should be aware that many Latinos of indigenous origin live in urban and rural communities throughout the United States. These populations, such as the Mixteco, Triqui, Zapotec, and Mayan Indians, often live within Latino immigrant communities but are proficient only in their indigenous languages. They may feel even further isolated among Spanish-speaking populations (Kearny, 1995).

The dearth of bilingual Latino health care professionals may prevent Latino individuals and families who prefer to have providers that speak their language and share their culture from seeking health care (Spector, 1991). When the patient or family speaks solely Spanish, the lack of certified medical interpreters poses an additional barrier (Glenn-Vega, 2002; Jackson et al., 2001). According to a recent survey, 44% of Latino adults have difficulty communicating with their doctors due to a language barrier, and of the Latinos who need an interpreter, only 49% always or usually receive interpreter services (Doty, 2003). Some facilities are equipped with sufficient bilingual staff; however, without appropriate training regarding interpretation techniques and medical terminology, miscommunication may lead to medical errors.

The Institute of Medicine report, *Unequal treatment: Confronting racial and ethnic disparities in health care* (Smedley, Stith, & Nelson, 2002), identifies the consequences of culturally incompetent medical

A limited ability to speak English among Spanish- or indigenous-speaking Latinos dissuades them from seeking care.

care. The report highlights the unequal treatment of underrepresented minority populations even when health care barriers are overcome. This unequal treatment is related in part to the lack of access to appropriate linguistic services such as bilingual health professionals and appropriately conducted interpreter sessions (Smedley et al., 2002). Flores, Milagros, Olivar, and Kastner (1998) also identified typical errors made through medical interpretation and their potential clinical consequences in medical encounters. This study was based on interpretation encounters with lay interpreters such as ancillary hospital staff or family members. This research found that lay interpreters were significantly more likely to make errors of clinical consequence than certified interpreters. In short, family members, especially children, and untrained bilingual staff should not be used as interpreters when relaying medical information of a sensitive nature such as HIV test results.

It is essential that health care providers follow culturally appropriate guidelines when caring for HIV-positive Latino patients. It is also imperative that physicians and other health care providers understand the consequences of improper or suboptimal care. Without effective encounters, significant variations in treatment may persist, resulting in adverse patient outcomes that may include a misdiagnosis, lack of *confianza* (trust), exacerbated illness, or even death (Sogocio, Barr, Golde, & Rasperch, 1998).

A number of variations of Spanish are spoken in the United States because of diverse immigration patterns from South and Central America, Mexico, and the Caribbean. Like other languages, regional translation and interpretation of materials and documents is required to accommodate for the variation in words and terminology. Variation in Spanish use or fluency relates to background, residence, age, education, acculturation, and/or social and political factors. Many Latinos who have been raised in the United States may not speak any Spanish at all. Knowledge and fluency in Spanish is most common among older people, recent immigrants, and Latinos who live along the U.S.-Mexico border. Latinos born in the United States tend to use Spanish less frequently than their immigrant counterparts (Pew Hispanic Center & Kaiser Family Foundation, 2002).

Variations exist not only in spoken Spanish, but also in cultural behaviors, practices, and beliefs. It is incorrect to assume that just because a health professional is Latino, he or she would not benefit from cultural sensitivity training for the population being served. Language and cultural knowledge of particular Latino subgroups should be considered a competency, and therefore evaluated through personal and/or organizational assessments. If deficiencies are recognized, training should be provided.

As a component of language, the reading level of materials disseminated to Latino communities needs to be evaluated for the appropriateness to the target audience. Latinos face enormous educational barriers in this country and in many of their countries of origin and thus many suffer from literacy-related deficiencies. One study conducted by Gandara (2001) showed that only one-third of Latino children attended preschool programs, only one-third of Latino elementary school children were taught by teachers certified in the courses they were teaching, and half of Latinos dropped out of school prior to completing their high school diploma. Without consideration to literacy-level specificity in both Spanish and English, HIV prevention information materials will be of little or no use to a large percentage of Latinos at risk for HIV infection.

Networking with Spanish language radio and television stations has been an effective way of communicating and disseminating important prevention information to the Latino community, and these efforts must be continued. In order to maximize exposure to culturally and linguistically appropriate HIV prevention education, health care organizations should attempt to reach linguistically isolated households wherein Spanish or an indigenous language is the only language spoken (Valdés, 2000). Health care providers should also maintain relationships with certified interpreters who can be available to interpret for their patients with limited English proficiency.

Access to Care and HIV Testing

Latinos are the largest group of uninsured and underinsured and are twice as likely to lack health insurance as the U.S. population overall (CDC, 1996; Quinn, 2000; Trevino, Moyer, Valdez, & Stroup-Benham, 1991; Weinick, Zuvekas, & Cohen, 2000). Of the 44 million uninsured Americans, one-quarter are Latino (Perry, Kannel, & Castillo, 2000). In 2002, Latinos comprised 13.7% of the total population but 29% of the uninsured (Doty, 2003). The number of Latinos in the United States lacking health insurance is increasing. For example, in the first half of 2003, 38.5% of U.S. Latinos were uninsured (Medical Expenditure Panel Survey, 2004). Subpopulation differences exist in insurance coverage, with 39% of Mexican Americans, 19% of Puerto Ricans, and 21% of Cuban Americans being uninsured (Carrillo, Treviño, Betancourt, & Coustasse, 2001). Foreign-born Latinos are more likely than their U.S.-born counterparts to lack health insurance (Doty, 2003).

Latino uninsured rates have remained consistently high over the past decade due to a number of factors that include lack of citizenship,

economic barriers, educational status, workforce characteristics, and employers who do not offer benefits or provide them at a cost that is too expensive for low-wage-earning Latinos (Perry et al., 2000). Low income is a predictor of lack of health insurance, and Latinos often represent the working poor (Frank, Clancy, & Gold, 1993), with 87% of uninsured Latinos living in working families (Kaiser Family Foundation, 2000). A college graduate is twice as likely to have insurance coverage compared with an individual without a completed high school education, and 50% of Latinos are not completing high school. In 2000, 10% of Latinos aged 25-29 had a college degree compared with 18% of African Americans and 34% of Whites. Latino high school graduates are less likely to go to college than their African American and White counterparts, and approximately half of the Latinos who do attend college attend 2-year schools (Brindis, Driscoll, Biggs, & Valderrama, 2002). According to the U.S. Census Bureau (2002), the 4-year degree completion rate for Latinos was 8.7% compared with 25.8% of non-Latino Whites and 13.8% of African Americans.

Lack of health insurance is the most significant barrier to preventive care for the Latino population (CDC, 1996; Doty, 2003). Latinos are also more likely than Whites to obtain health care through public clinics or emergency services and to lack a usual source of health care. Twenty-five percent of Mexican Americans lack a regular source of care, which may also indicate that this group is less likely to seek out preventive services (Carrillo et al., 2001). This may, in part, explain why Latinos are more likely to learn of their HIV/AIDS status later in their illness than Whites (be diagnosed with AIDS at the time of their first HIV test or develop AIDS within 1 year of testing positive) (Kaiser Family Foundation, 2001).

Poverty serves as a major barrier to care as it directly affects a Latino patient's ability to (1) be insured, (2) maintain a regular source of care, and (3) afford prescribed medications. Although Latinos are more likely to have full-time employment when compared with other racial/ethnic minorities, 60% of Latinos live in families with incomes below 200% of the poverty level, and 41% of uninsured non-elderly Latinos have household incomes under \$15,000 per year (Doty, 2003). Other poverty-related barriers to access include a lack of transportation to health care clinics, a lack of childcare, a reluctance to miss work, and excessive waiting times in clinics (Flores et al., 1998). A phenomenon that has permeated many impoverished Latino communities is the notion that "if you are not sick enough to go to the emergency room, you are not sick enough [to see a doctor]" (White-Means, Thorton, & Yeo, 1989). This has created a system in which

Lack of health insurance is the most significant barrier to preventive care for the Latino population.

Latino individuals and families lack a regular source of health care. This is particularly problematic for Latinos infected with HIV, where consistent and constant access to a health care provider can help to form an alliance and *confianza* (trust) between the patient and the provider, and thus increase the effectiveness of care.

Migrant farm workers have unique barriers to care. It is estimated that there are 4.1 million migrant farm workers in the United States (Quander, 2001). The U.S. Department of Labor estimates that approximately 80% of migrant and seasonal farm workers are Latino (Quander, 2001). Migrant farm workers do not enjoy the rights or the benefits of the typical American worker. Health insurance and unemployment benefits are generally not an option, and in many cases migrant farm workers are not even guaranteed a minimum wage (Slesinger & Ofstead, 1993). The poverty that plagues farm workers manifests itself in many ways. In particular, it is obvious in their incomes, housing, home possessions, diet, nutrition, and social isolation. In addition to the linguistic, financial, and cultural barriers, migrant workers also face geographic limitations to HIV prevention and treatment services. Social and economic dynamics specific to border regions, such as sex trade, tourism, drug trafficking, and transnationalism can contribute to high rates of HIV infection among migrant workers (Quander, 2001).

Latinos often experience greater marginalization and inability to access HIV prevention information, testing, and management services. The scarcity of culturally and linguistically appropriate health care, HIV-related education targeting Latinos, lack of health care access, low socioeconomic status, fear of deportation, and perceived invulnerability to HIV infection often render the population at grave risk of infection. Although the incubation period of untreated HIV to AIDS is generally agreed to be 10 to 12 years, 65% of HIV-infected Latinos are diagnosed with AIDS within 1 year of learning of their HIV seropositivity. In addition, Latinos have been found to present for initial HIV testing at later stages of infection, with low CD4 cell counts and high viral loads (Neal & Fleming, 2002). This is of particular importance as studies have shown that having been tested for HIV and self-identifying as homosexual are often the strongest predictors of intention to test, and that heterosexual Latino males are the least likely to be tested (Fernández, Perrino, Royal, Ghany, & Bowen, 2002). Many Latino men engage in unprotected sex with a myriad of sexual partners without being fully aware of their infection.

The provider can play a crucial role in helping the patient comprehend his or her vulnerability to HIV infection. A survey that was

The provider can play a critical role in educating the Latino community by informing patients about the risks of HIV/AIDS and promoting assessment and testing.

completed with 255 Latino men who had never been tested for HIV revealed that 84% of the men had never been offered testing by a health care provider, and that 86% of the men would accept HIV testing if recommended by their doctor (Fernández et al., 2003). By educating patients about the risks of contracting HIV/AIDS and promoting assessment and testing, regardless of sexual orientation or history of IDU, the provider can play a critical role in educating the Latino community. Inasmuch as HIV and AIDS have been traditionally associated with homosexuals and injection drug users, health care providers are less likely to recommend HIV testing to married Latinas, who currently represent an increasing share of women with AIDS (Rios-Ellis, Leon, Trujillo, & Ugarte, 2003). One way to create an environment conducive to HIV testing targeting the Latino population is to frame it as an important preventive educational experience that will benefit not only the recipient, but the entire Latino family. Slogans such as “*Protege tu familia: Hazte la prueba*” or “*Protect your family: Get tested*” can be strong motivators for “mainstream” Latinos who do not readily identify with the predetermined at-risk populations consisting of homosexuals, injection drug users, and sex workers.

In a recent survey of Latinos who had never been tested, the two most prominent reasons for not getting tested were perceptions of not being at risk of HIV infection and not having thought about it (Hispanic Federation, 2003). Moreover, some Latinas may not have the cultural support, knowledge, or skills needed to effectively communicate topics of a sexual nature to their partners and, due to their partners’ behaviors, may be extremely vulnerable to HIV (Amaro, Navarro, & Conron, 2002; Gómez & Marín, 1996).

Constructs of Culture and Gender

Cultural beliefs, traditional gender roles, and sexual norms may become barriers to care for Latino patients infected with HIV. Deep-rooted religious beliefs and values have heavily shaped most Latino cultures. The traditional Latino family constellation is that of a heterosexual couple with children. Diversions from this lifestyle are perceived by some as a rejection of religious and cultural values. Individuals may delay or refuse treatment because of the advice and opinions of family members, thus demonstrating the importance of familismo to the Latino patient. In some cases, a family member’s advice and suggestions can be deemed more valuable to the patient than the advice and recommendations made by the health care provider. The cooperation and/or approval of the head of family (typ-

ically a husband or father) may be important for initiating treatment or other interventions, in particular for female and/or young family members. It is common for Latinos to feel uncomfortable when asked to speak openly about sexual practices and condom use, particularly in front of family members (especially those of the opposite sex). Speaking about sexual practices with strangers and in public is not commonly accepted by Latino culture. Latino men who are not monogamous, although married or in a long-term relationship, may not disclose sexual encounter with men and/or women to their significant other (Scott, Jorgensen, & Suarez, 1998). These practices make it difficult to recruit Latinos into traditional HIV prevention and intervention activities that openly discuss the risks involved with different sexual practices. In addition, Latino men and women have demonstrated negative attitudes toward the use of condoms due to their association with illness, sex work, and emotional distance (Marin, Tschann, Gomez, & Kegeles, 1993; Peragallo, 1996).

Gender differences may also play a role in the ability of Latinos to access health services and HIV prevention education. For women, embarrassment about discussing sexual matters may delay or prevent access to gynecologic or HIV preventive services. Childcare and responsibilities toward other family members may reduce the priority for their own health care. Latinas who attempt to convince their partners of safe sexual practices fear suspicion by their partner of being unfaithful or untrusting. Latinas may also fear confrontation that could result in domestic violence, especially if there is an economic dependence on the male partner. When rape and coerced sexual relations occur, it is often within long-term relationships, thus increasing the possibility of unprotected sex resulting in HIV infection (Zierler & Krieger, 1997). A recent qualitative national HIV needs assessment of Latinas revealed that expectations related to marriage resulted in a false sense of security among married Latinas. Many HIV-positive participants reported experiencing long-term abusive relationships, including domestic rape which precipitated their HIV infection (Rios-Ellis, Dwyer, Leon, & Ugarte, 2002).

Research demonstrates that involuntary sexual encounters represent a substantial source of HIV risk for Latinas. More Latinas under the age of 16 (18%) than Whites and African Americans (15% respectively), report that their first sexual encounter was involuntary (Giachello & Arrom, 1997). Protection is rarely used during involuntary sexual encounters, placing young Latinas at grave risk of HIV infection. Harrison, Wambach, and Byers (1991) found that even when confronting clear risk of HIV infection, almost half of Latinas stated that they would not use condoms with a primary partner who was HIV infected.

For Latino men, issues of masculinity (*machismo*), and values regarding self-sufficiency and distrust of medical treatment may delay access to preventive or treatment services (Morales, 2003). U.S. immigration as experienced by Latinos has also had a negative effect on the ways in which *machismo* impacts HIV risk behavior. When confronted with a society that prescribes equality for both genders while not assuring male economic success and therefore the ability to provide, *machismo*, coupled with disempowerment, may result in gender role discrepancy conflicts (Pleck, 1995). Due to a sense of *machismo*, Latino males may perceive themselves as invulnerable to HIV infection and refuse to use protection, and/or engage in HIV testing and treatment. Reasons that have been cited for refusal to use condoms among Latino males include decreased pleasure, loss of erection, time and discomfort related to their use, needing to use condoms only with promiscuous women, decreased *confianza* and intimacy, alcohol and drug use, and decreased spontaneity. Due to the high level of HIV infection among Latino couples, the documented resistance to condom use, and the lack of understanding regarding risk of infection among discordant couples, providers must be diligent in their suggestions and instructions regarding the importance of consistent and proper condom use (Rios-Ellis, Leon, Trujillo, & Ugarte, 2004).

A commonly held belief among Latinos is that events are meant to happen to them because of fate, luck, or powers beyond their control. A sense of fatalism (*fatalismo*) may convince some Latinos that it is in their destiny to be afflicted with HIV/AIDS. Latinos are more likely than their White counterparts to think that chronic disease is determined by God and therefore must be accepted and endured as a *castigo divino* (divine punishment) for personal sins or sins of family members (Baquet & Hunter, 1995). Health is viewed synergistically by Latino cultures and is regarded as a continuum of mind, body, and spirit (Antshel, 2002). In Latino cultures, there is an extensive practice of traditional medicine carried out by *curanderos* (traditional folk healers). Traditional healing practices among Latinos also include the use of *botanicas* (herbal and spiritual pharmacies) when seeking a treatment or cure (Higginbotham, Trevino, & Ray, 1990). This may become problematic if *curanderismo* is practiced to the exclusion of appropriate Western medical treatment. These practices may also conflict with Western medical care if the health care provider is unaware of complementary treatments with herbs and other pharmacoactive substances that may counter or complicate medical regimens.

Fear of Stigma

For many infected by, or at risk for HIV infection, fear may be the most substantial barrier in accessing care. In general, an HIV or AIDS diagnosis often results in stigmatization, and Latinos affected by this disease often experience even greater stigmatization due to the myriad of misconceptions regarding HIV in their respective communities. The association of HIV infection with sex work, homosexuality, sexual promiscuity, and IDU, even when just perceived or feared, may jeopardize an individual's social support and family network. As opposed to risking the rejection of family and friends and endangering a social network, many Latinos would rather not know of yet another factor that could negatively impact an already precarious social environment. For example, Latinos who have recently immigrated may already experience a reduced social network and may not want to threaten the small support system they have in place with the knowledge of an HIV diagnosis. Many Latinos may prefer to avoid testing altogether rather than risk finding out about a positive HIV test. For some Latinas, admitting that their husbands may have infected them through infidelity could possibly be interpreted as domestic failure in their role as a wife (Shedlin, 1990).

Latino men who have sex with men (MSMs) are less likely than their White counterparts to disclose either their sexual orientation or HIV status to significant others, especially family members (Mason, Marks, Simoni, Ruiz, & Richardson, 1995). Many homosexual and bisexual Latino men and women do not seek HIV health care services because of fear of stigmatization by their communities for their lifestyle, and married heterosexual Latinas often do not recognize their vulnerability to HIV until they undergo prenatal screening or their husbands are ill or dying (Rios-Ellis et al., 2003). Some homosexual or bisexual Latinos may return to their rural home or communities because of a loss of gainful employment as a result of a positive HIV test. Their loss of employment often results in a loss of insurance, and they may never seek treatment or tell their families they are infected (Carrillo et al., 2001). Homosexual/bisexual Latinos living in rural communities may never seek services, even when they are symptomatic, for fear of loss of support systems, particularly family.

Intravenous heroin use has been endemic in poor (usually urban) Latino communities since the 1950s and carries with it a strong stigma related to IDU. Puerto Ricans were the Latino population hardest hit in the first stages of the HIV pandemic due to IDU. With increasing intergenerational patterns of abuse, younger Latinos are being introduced into IDU earlier in their lives. The lack of culturally and linguistically

Fear of stigma is a barrier to accessing care.

appropriate drug treatment on demand, and the stigma that methadone maintenance (the greatest HIV prevention strategy for this group) holds even within the drug community, hampers some Latinos from recovering from IDU. Women who use intravenous drugs are further stigmatized by their communities because of traditional gender roles that are held within the Latino culture that makes illegal behaviors less acceptable for women than for men. Treatment programs that enable single mothers to participate with their children and without the risk of losing parental custody are essential to enhance the participation of Latina injection drug users (Vega, Gil, & Kolody, 2002).

Recently immigrated populations may not access screening, prevention, and/or treatment services for fear of deportation. Undocumented Latinos may worry about the risk of being detected if they seek health care. Once HIV or AIDS is diagnosed, immigrants are not able to obtain full legal permanent residency or citizenship and thus frequently do not qualify for full Medicaid benefits (Morales, 2003). Furthermore, the recent increase in deportation raids by the Immigration and Naturalization Service (INS) have resulted in a substantial decrease in clinic and hospital visits and appointments for fear of deportation (National Council of La Raza, 2004).

Bias of Health Care Providers

The attitudes of health care providers can directly impact the ability of HIV-infected Latinos to seek or use health care services. Racism and resulting discrimination constitute significant barriers to health care for Latinos living with HIV/AIDS. Previous research has shown that HIV-infected Latinos are less likely than Whites to receive adequate treatment for their infection even when controlling for variables such as age, insurance coverage, and education (Kaiser Family Foundation, 1999). Health care providers themselves may hold biases that can become barriers to care. Some health care providers may have difficulty understanding why a Latino patient who has lived in the United States for a number of years is reluctant to learn English. Latino patients may perceive English-only signage/written materials and a lack of Spanish-speaking personnel as unwelcoming or discriminatory (Collins, Hall, & Neuhaus, 1999).

Latino patients who speak English with a heavy Spanish accent may be perceived by some health providers as less educated than they really are. A study on public perceptions of racism as it affects the health care system revealed that 51% of all Latinos interviewed felt

Health care providers may hold biases that can become barriers to care.

that the health system treats people unfairly based on their race or ethnicity (Lillie-Blanton, Brodie, Rowland, Altman, & McIntosh, 2000). Meanwhile, 43% of Whites felt that one's race or ethnicity rarely affects how they are treated by the health care system, and 11% of Whites said they were unsure of its effect. In addition, 72% of Latinos compared with 57% of Whites were of the opinion that the unfair treatment by the health care system was largely based on one's English-speaking ability. However, both groups were equally likely (69%) to identify a lack of health insurance as a reason for inequitable treatment by the health care system. Unsurprisingly, 15% of Latinos compared with 1% of Whites felt that they personally had been treated unfairly by a health care provider based on their race or ethnicity, and 14% of Latinos compared with 1% of Whites felt they had been treated unfairly based on their ability to speak English. The results from this particular study also indicate that there were no significant differences in the source of medical care among the different ethnic groups, with the majority of the respondents seeking medical care at a doctor's office.

There has been an increased sensitivity to and bias toward immigrants in this country since the 9/11 tragedy. The immigration status of Latino patients may come into question by health providers, particularly if Latinos speak with a heavy accent and lack health insurance. Health care providers may not be aware that some Latinos who have recently migrated to the United States may have the rights of citizens or residents (e.g., Puerto Ricans and Cubans) while others may not (e.g., Mexicans and Central and South Americans).

Some providers are bothered by having to explain a patient's illness or health status to a large group of family members that typically accompany the Latino patient. This is complicated further by new Health Insurance Portability and Accountability Act (HIPAA) guidelines requiring strict confidentiality of health information to the patient alone. The low representation of Latinos in health professions further increases the barrier to high quality appropriate care. Research indicates that better outcomes are produced from patient-provider relationships when the provider shares the same race, ethnicity, or cultural background with the patient (Purnell & Paulanka, 1998). Latinos can benefit from physicians who share not only their culture, but also their language; studies show that Spanish-speaking Latino patients are more satisfied with their care when their provider can speak Spanish (Carrillo et al., 2001). This becomes a problem for the Latino community because there is such a low representation of Latinos among physicians and other health care providers. While Latinos make up 13.2% of the population, they account for only 5.1% of physicians and surgeons, 3.3% of nurses, 3.6% of dentists, and 3.2% of pharmacists (U.S. Census

Bureau, 2000). The low number of Latino health care professionals is a problem that stems from many factors, including discrimination, marginalization, and the 50% high school dropout rate among Latino youth. This extremely elevated dropout rate affects the numbers of Latinos going on to universities and medical schools, resulting in a very small number of Latino medical professionals (Marwick, 1999). Anti-affirmative action legislation has also decreased the number of Latino applicants to medical programs within the past 5 years.

Another health care provider bias is demonstrated by the lack of research on sexual attitudes, behaviors, and risky sexual practices among Latinos and specific Latino subpopulations. The lack of reliable data collection and monitoring by insurance companies and providers about Latinos and Latino subgroups was outlined in the Institute of Medicine report, *Unequal treatment: Confronting racial and ethnic disparities in health care* (Smedley et al., 2002). The Institute of Medicine report recommends collection of racial and ethnic health care data to evaluate and monitor the effectiveness of programs and identify the need for, and deployment of, resources for the provision of culturally and linguistically appropriate services (Smedley et al., 2002).

Conclusion

Clearly, there are a number of barriers Latinos face in attempting to access HIV screening, prevention, and treatment services. The Institute of Medicine report (Smedley et al., 2002) outlines recommendations for the elimination of health care disparities for all racial and ethnic groups. The Culturally and Linguistically Appropriate Services (CLAS) Standards provide a framework for practitioners and organizations in delivering high quality, appropriate health care services for those within the Latino community who are at risk, or affected by, HIV/AIDS (OMH, 2001). Eliminating barriers to care for Latino communities and individuals at risk, or affected by, HIV/AIDS will (1) provide an effective response to the demographic change in the United States as evidenced by the 2000 U.S. Census; (2) reduce and eliminate disparities in the health status of all Latinos; and (3) improve the quality and outcome of HIV/AIDS prevention, intervention, and treatment services.

References

- Amaro, H., Navarro, A., & Conron, K. (2002). Cultural influences on women's sexual health. In G.M. Wingood & R.J. DiClemente (Eds.), *Handbook of women's sexual and reproductive health* (pp. 71-92). New York: Kluwer Academic/Plenum Publishers.
- Antshel, K.M. (2002). Integrating culture as a means of improving treatment adherence in the Latino population. *Psychology, Health & Medicine*, 7(4): Brunner Routledge Publishers.
- Baquet, C.R., & Hunter, C.P. (1995). Patterns in minorities and special populations. In P. Greenwald, B. Kramer, & D.L. Weed (Eds.), *Cancer prevention and control* (pp. 23-6). New York: Marcel Decker, Inc.
- Brach, C., & Fraser, I. (2002). Reducing disparities through culturally competent health care: An analysis of the business case. *Quality Management in Health Care*, 10(4), 15-28.
- Brindis, C.D., Driscoll, A.K., Biggs, M.A. & Valderrama, L.T. (2002). Fact sheet on Latino youth: Education. San Francisco: University of California, San Francisco.
- Carrillo, J.E., Treviño, F.M., Betancourt, J.R., & Coustasse, A. (2001). Latino access to health care: The role of insurance, managed care, and institutional barriers. In M. Aguirre-Molina, C. Molina, & R. Zambrana (Eds.), *Health issues in the Latino community* (pp. 55-73). San Francisco: Jossey Bass Publishers.
- Centers for Disease Control and Prevention. (1996). National Center for Health Statistics. <http://www.cdc.gov/nchs>.
- Centers for Disease Control and Prevention. (2001). *HIV/AIDS surveillance report year end edition*, 13(2). Atlanta, GA: Centers for Disease Control and Prevention.
- Centers for Disease Control and Prevention. (2002). HIV/AIDS among Hispanics in the United States: Fact sheet. <http://www.cdc.gov/hiv/pubs/facts/hispanic.htm>.
- Collins, K.S., Hall, A., & Neuhaus, C. (1999). U.S. minority health: A chartbook. New York: The Commonwealth Fund.
- Colorado AIDS Education and Training Center. (2003). *Puertas de diversidad: Culturally guided interventions with Latinos*. Colorado Springs, CO.
- Derose, K.P., & Baker, D.W. (2000). Limited English proficiency and Latinos' use of physician services. *Medical Care Research and Review*, 57(1), 76-91.
- Doty, M. (2003). *Insurance, access, and quality of care among Hispanic populations: A chartpack*. New York: The Commonwealth Fund.
- Fernández, M.I., Bowen, G.S., Perrino, T., Royal, S., Mattson, T., Arheart, K.L., et al. (2003). Promoting HIV testing among never-tested Hispanic men: A doctor's recommendation may suffice. *AIDS and Behavior*, 7(3), 253-62.

- Fernández, M.I., Perrino, T., Royal, S., Ghany, D., & Bowen, G.S. (2002). To test or not to test: Are Hispanic men at highest risk for HIV getting tested? *AIDS Care, 14*(3), 375-84.
- Flores, G., Milagros, A., Olivar, M.A., & Kastner, B. (1998). Access barriers to health care for Latino children. *Archives of Pediatrics & Adolescent Medicine, 152*, 1119-25.
- Frank, P., Clancy, C.M., & Gold, M.R. (1993). Health insurance and subjective health status: Data from the 1987 National Medical Expenditure Survey (NMES). *American Journal of Public Health, 83*, 1295-1301.
- Gandara, P. (2001). *Lost opportunities: The difficult journey to higher education for under-represented minority students*. Symposium on Diversity in the Health Professions in Honor of Hebert W. Nickens, National Academy of Science: Washington, DC.
- Giachello, A., & Arrom, J. (1997). Health service access and utilization among adolescent minorities. In D.K. Wilson, J.R. Rodriguez, & W.C. Taylor (Eds.), *Health-promoting and health-compromising behaviors among minority adolescents* (pp. 303-320). Washington, DC: American Psychological Association.
- Glenn-Vega, A. (2002). Achieving a more minority-friendly practice. *Family Practice Management, 9*(6), 39-43.
- Gómez, C.A., & Marin, B.V. (1996). Gender, culture, and power: Barriers to HIV prevention strategies for women. *Journal of Sex Research, 33*, 355-62.
- Harrison, D., Wambach, K., & Byers, J. (1991). AIDS knowledge and risk behaviors among culturally diverse women. *AIDS Education & Prevention, 3*(2), 79-89.
- Higginbotham, J.C., Trevino, F.M., & Ray, L.A. (1990). Utilization of *curanderos* by Mexican Americans: Prevalence and predictors. *The American Journal of Public Health, 80*(12), 32.
- Hispanic Federation. (2003). *HIV/AIDS in the Latino community* (pp. 1-4). New York: Hispanic Federation.
- Jackson, S., Camacho, D., Freund, K.M., Bigby, J.A., Walcott-McQuigg, J., Hughes, E., et al. (2001) Women's health centers and minority women: The National Center of Excellence in Women's Health. *Journal of Women's Health and Gender-Based Medicine, 10*(6), 551-9.
- Kaiser Family Foundation. (1999). *A synthesis of the literature: Racial and ethnic differences in access to medical care*. Menlo Park, CA: Kaiser Family Foundation.
- Kaiser Family Foundation. (2000). Press Release: New report provides critical information about health insurance coverage and access for racial and ethnic minority groups: Most minority Americans are working yet lack job-based coverage. <http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13342>

- Kaiser Family Foundation. (2001). *Key facts: Latinos and HIV/AIDS*. Washington, DC. Report #6088.
- Kaiser Family Foundation: Kaiser Commission on Medicaid and the Uninsured. (2003). *Health insurance coverage in America: Data update*.
- Kearney, M. (1995). The effects of transnational culture, economy, and migration on Mixtec identity in Oaxaca, California. In M.P. Smith, & J. Feagin (Eds.), *The bubbling cauldron: Race, ethnicity, and the urban crisis* (pp. 226-43). Minneapolis: University of Minnesota Press.
- Lillie-Blanton, M., Brodie, M., Rowland, D., Altman, D., & McIntosh, M. (2000). Race, ethnicity, and the health care system: Public perceptions and experiences. *Medical Care Research & Review*, 57(1), 218-35.
- Marin, B.V., Tschann, J.M., Gomez, C., & Kegeles, S.M. (1993). Acculturation and gender differences in sexual attitudes and behaviors: A comparison of Hispanic and non-Hispanic white unmarried adults. *American Journal of Public Health*, 83, 1759-61.
- Marin, G., & Gamba, R.J. (1996). A new measurement of acculturation for Hispanics: The Bidimensional Acculturation Scale for Hispanics (BAS). *Hispanic Journal of Behavioral Science*, 18(3), 297-316.
- Marwick, C. (1999). Growing Hispanic association serves increasing population. *Journal of the American Medical Association*, 281(18), 1687-8.
- Mason, R.C., Marks, G., Simoni, J.M., Ruiz, M.S., & Richardson, J.L. (1995). Culturally sanctioned secrets? Latino men's nondisclosure of HIV infection to family, friends, and lovers. *Health Psychology*, 14(1), 6-12.
- Medical Expenditure Panel Survey. (2004). Statistical Brief #41: *The uninsured in America, 2003—Estimates for the U.S. population under age 65*.
- Morales, S. (2003). Care of Latinos in cross-cultural medicine. In J.A. Bigby (Ed.), *Cross-cultural medicine* (pp. 61-95). Philadelphia: American College of Physicians.
- National Alliance of State and Territorial AIDS Directors. (2003). *Addressing HIV/AIDS: Latino perspectives & policy recommendations*. Ayala, G., and Nuno, M. Washington, DC: NASTAD.
- National Council of La Raza. (2004). Press release: NCLR calls on Bush administration to cease immigration raids in California interior. <http://www.nclr.org/content/news/detail/25365/>
- National Minority AIDS Education and Training Center. (2002). *BE SAFE: A cultural competency model for African Americans*. J. McNeil (Ed.), J. Campinha-Bacote, E. Tapscott, & G. Vample. Washington, DC: Howard University.
- Neal, J., & Fleming, P. (2002, February). Frequency and predictors of late diagnosis in the United States, 1994 through 1999, 9th Conference on Retroviruses and Opportunistic Infections, Poster Presentation 474M, Centers for Disease Control and Prevention.

- Office of Minority Health. (2001). *National standards for culturally and linguistically appropriate services in health care: Final report* (pp. 3-131). Washington, DC: U.S. Department of Health and Human Services.
- Peragallo, N. (1996). Latino women and AIDS risk. *Public Health Nursing, 13*(3), 217-22.
- Perry, M., Kannel, S., & Castillo, E. (2000). *Barriers to health coverage for Hispanic workers: Focus group findings*. New York: The Commonwealth Fund.
- Pew Hispanic Center, & Kaiser Family Foundation. (2002). *2002 National survey of Latinos*. Menlo Park, CA, and Washington, DC.
- Pleck, J.H. (1995). The gender role strain paradigm: An update. In R.F. Levant & W.S. Pollack (Eds.), *A new psychology of men*. New York: Basic Books.
- Purnell, L., & Paulanka, B. (1998). *Transcultural health care: A culturally competent approach*. Philadelphia: F.A. Davis Co.
- Quander, L. (2001). Reducing HIV/AIDS risk among migrant farm workers. *HIV Impact*. Spring: Vol. 8.
- Quinn, K. (2000). *Working without benefits: The health insurance crisis confronting Hispanic Americans*. New York: The Commonwealth Fund.
- Rios-Ellis, B., Dwyer, M., Leon, R., & Ugarte, C. (2002, July). *From voices to action: Evolution of a multi-site needs assessment of Latinas and HIV/AIDS*. Presentation made at the National Council of La Raza Conference, Miami, FL.
- Rios-Ellis, B., Leon, R., Trujillo, E., & Ugarte, C. (2003, March). *Latinos and HIV: A national picture*. Presentation made at the National Hispanic Medical Association's Annual Conference, Washington, DC.
- Rios-Ellis, B., Leon, R., Trujillo, E., & Ugarte, C. (2004, June). *Una familia unida se protege mejor: Using a family-based approach to HIV prevention*. Presentation made at the National Council of La Raza Conference, Phoenix, AZ.
- Scott, S.A., Jorgensen, C.M., & Suarez, L. (1998). Concerns and dilemmas of Hispanic AIDS information seekers: Spanish-speaking callers to the CDC National AIDS hotline. *Health Education and Behavior, 25*(40), 501-16.
- Shedlin, M. (1990). An ethnographic approach to understanding HIV high-risk behaviors: Prostitution and drug abuse. In C.G. Leukefeld & R.J. Battjes (Eds.), *AIDS and intravenous drug use: Future directions for community-based prevention research* (pp. 134-49). Rockville, MD: National Institute on Drug Abuse.
- Slesinger, D.P., & Ofstead, C. (1993). Economic and health needs of Wisconsin migrant farm workers. *Journal of Rural Health, 9*(2), 138-48.
- Smedley, B.D., Stith, A.Y., & Nelson, A.R. (2002). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Institute of Medicine Report. Washington, DC: National Academy of Science.

- Sogocio, T., Barr, D., Golde, M., & Rasperch, L. (1998). *An overview of research on clinical practice guideline dissemination, implementation, and evaluation*. Menlo Park, CA: Kaiser Family Foundation. http://www.hivforum.org/publications/dissemination_guidelines.pdf
- Solis, J.M., Marks, G., Garcia, M., & Shelton, D. (1990). Acculturation, access to care and use of preventive services by Hispanics: Findings from the HHANES, 1982-84. *American Journal of Public Health, 80*(Suppl. 12), 11-19.
- Spector, R.E. (1991). *Cultural diversity in health and illness* (3rd ed.). Norwalk, CT: Appleton & Lange.
- Trevino, F.M., Moyer, M.E., Valdez, K.B., & Stroup-Benham, C.A. (1991). Health insurance coverage and utilization of health services by Mexican-Americans, mainland Puerto Ricans, and Cuban Americans. *Journal of the American Medical Association, 265*(2), 233-7.
- U.S. Census Bureau. (2000). Census 2000 EEO Data Tool: Data Results for Total US: <http://www.census.gov>
- U.S. Census Bureau. (2002). Percent of high school and college graduates of the population 15 years and over, by age, sex, race, and Hispanic origin. <http://www.census.gov>
- Valdés, M.I. (2000). *Marketing to American Latinos: A guide to the in-culture approach*. Ithaca, NY: Paramount Market Publishing.
- Vega, W., Gil, A. Kolody, B. (2002). What do we know about Latino drug use? Methodological evaluation of State databases. *Hispanic Journal of Behavioral Sciences, 24*(4), 395-408.
- Weinick, R.M., Zuvekas, S.H., & Cohen, J.W. (2000). Racial and ethnic differences in access to and use of health care services, 1977 to 1996. *Medical Care Research and Review, 57*(1) Suppl:36-54.
- White-Means, S.L., Thornton, M.C., & Yeo, J.S. (1989). Sociodemographic and health factors influencing Black and Hispanic use of the hospital emergency room. *Journal of the National Medical Association, 81*, 72-80.
- Zierler, S., & Krieger, N. (1997). Reframing women's risk: Social inequalities and HIV infection. *Annual Review of Public Health, 18*, 401-36.

Suggested Readings

- Office of Minority Health. (2001). National standards for culturally and linguistically appropriate services in health care: Final report (pp. 3-131). Washington, DC: U.S. Department of Health and Human Services.
- Smedley, B.D., Stith, A.Y., & Nelson, A.R. (2002). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Institute of Medicine Report. Washington, DC: National Academy of Science..

Four guiding ethical principles:

- **Autonomy**
- **Beneficence**
- **Non-maleficance**
- **Justice**

Ethics

Four guiding ethical principles should be incorporated into any health care setting: **autonomy** (ensuring respect for a person's right to make his or her own decisions), beneficence (acting for the benefit of the patient or putting the patient's best interests first), **non-maleficance** (taking care not to harm or injure the patient), and **justice** (treating patients in similar circumstances equally and distributing resources fairly) (Lo, 2000a).

Autonomy means giving the patient the information he or she needs to make an informed decision and then allowing the patient to make the decision. The principle of autonomy is most difficult to implement when the patient lacks the capacity (because of age or physical or mental illness) to make rational choices. To ensure that patients are empowered to make their decisions, providers should provide resources for those who are disadvantaged by literacy or language issues, including interpreters for non-English-proficient patients and documents in the patient's native language.

The second principle, **beneficence**, requires that health care providers act in the best interest of their patients by providing competent and timely care within the bounds of clinically accepted practices. The third principle, **non-maleficance**, which requires providers to avoid causing patients any harm, may sometimes be difficult for health care providers to apply. For example, the provider may be required by State law to disclose information that he or she knows will be used for partner notification, even though release of that information has the potential to harm the HIV-infected patient. The provider can limit the harm and honor the principle of autonomy by informing the patient before making the disclosure.

The fourth principle, **justice**, requires that health care providers treat all individuals fairly regardless of their race, ethnicity, religion, sexual orientation, or health status. Latinos infected with HIV may experience discrimination on multiple levels. For example, a Latino male who engages in sex with men may experience discrimination due to his ethnicity, his sexual practices, his immigration status, and his limited proficiency in English. Complying with the justice principle requires that health care providers analyze their own personal beliefs and biases and make conscientious efforts to treat all of their patients fairly.

Confidentiality and Testing

Testing options available for HIV include using *anonymous* (no-name) HIV testing, which uses a number instead of the individual's name. This option allows individuals to find out about their HIV status without worrying about the results of the test being revealed to others. Typically administered at anonymous testing sites, anonymous HIV tests ensure that only the individual being tested will have access to the test results. *Confidential* HIV testing requires the individual being tested to reveal his or her name to the health care worker administering the test. With confidential HIV testing, the individual's test results will be available to the health care provider that performed the test and the results may become part of the individual's medical file. It is the ethical responsibility of the health care provider to inform the individual being tested as to exactly who will be able to access the individual's test results. The results of HIV testing are confidential with the exception of name reporting to State or county public health departments, which is required in some, but not all, States (Lo, 2000b). Currently, AIDS cases are reported by name to State or county public health departments in all 50 States.

There has been much recent debate about the value of anonymous (no-name) testing (Gostin, Ward, & Baker, 1997). The introduction of OraQuick, which can be used during street outreach and provides HIV test results within 20-60 minutes and thus increases the opportunities for anonymous testing, has spurred some of this debate. Health officials throughout the Nation have been advocating an end to anonymous testing, arguing that name-based testing results in the collection of better and more accurate epidemiologic data, which is important considering the increasing rates of HIV infection and the effectiveness of anti-retroviral medication in delaying the onset of AIDS (Gostin et al., 1997). Many HIV/AIDS service organizations are proposing a system of testing that will satisfy the arguments of both sides: using unique identifiers to provide for more accurate epidemiologic data while still maintaining the privacy of the patient (San Francisco AIDS Foundation, 1998).

Those who support anonymous testing point to the possible adverse consequences to the patient if HIV-related information is disclosed. The very fact that an individual has asked for a test may be read by insurers as acknowledgement of HIV risk. In some States, the individual may have difficulty obtaining insurance (or have his or her insurance canceled) or may suffer discrimination in treatment or employment (although discrimination in treatment or employment is outlawed by the Americans with Disabilities Act and many State laws). Finally, a positive test for HIV will trigger partner notification procedures (discussed below).

Anonymous HIV testing:

Only the individual who is being tested has access to the test results.

Confidential HIV testing:

Test results are available to the individual who is being tested and to the health care provider that gave the test. Results may become part of the individual's medical file. In some States, names may be reported to State or county health departments.

The Centers for Disease Control and Prevention (CDC) and other organizations continue to recommend that anonymous testing be offered (CDC, 1999). Organizations such as the San Francisco AIDS Foundation are strongly against the termination of anonymous testing because they fear this will cause individuals with a high risk for HIV infection to avoid testing and treatment (SFAF, 1998). Many individuals who are reluctant to access confidential name-based testing would not otherwise do the testing were it not for anonymous testing opportunities. Moreover, research suggests that people who test anonymously are much more likely to return for their test results than those who take name-based confidential tests (Hertz-Picciotto, Lee, & Hoyo, 1996).

As long as anonymous testing is available, the principle of autonomy requires that health care providers inform patients of that option. If the patient decides to undergo name-based testing, the provider should tell him or her of the name of the governmental entity that will receive the test result and what information will be disclosed (e.g., whether the patient's name will be included). As part of the informed consent process, the provider should also inform the patient about the partner notification procedures required in the State. Finally, the provider should inform patients who are considering name-based testing that when HIV-related information (such as test results) is placed in their records, that information may be included when the patient consents to disclosure of medical information. Providers should also inform the patients of potential adverse consequences of that disclosure.

Confidentiality and Disclosures

The stigmatization that accompanies seropositive status has prompted some States to enact laws to provide extra protection for the medical records of HIV-positive individuals. In many States, that protection includes specific requirements regarding the forms patients must sign to consent to disclosures, as well as special protection in instances in which court orders for information are sought.

The provider should know what the State law requirements are for patients consenting to disclosure of HIV-related information. In some States, a simple medical release is not sufficient to authorize disclosure of HIV-related information. The provider should discuss with the patient the possible adverse consequences of disclosure of HIV-related information before the patient consents to any such disclosures.

Confidentiality and Discretion

It is important for the provider to remember that the maintenance of strict confidentiality facilitates trust between the health care provider and the Latino patient with HIV infection or AIDS, as well as the development of dignity and respect in the relationship. These qualities are key components of effective relationships with Latino HIV/AIDS patients who value relationships that incorporate the elements of *respeto* (respect) and *confianza* (trust).

Partner Notification

CDC encourages States to devise partner notification services that are “voluntary, confidential, conducted in a collegial and cooperative manner, and are sensitive to potential consequences of notification, such as damage to relationships and potential violence” (CDC, 1997, p. 1). Each State law regarding partner notification is different. Health care providers should know what the law in their State specifies and should inform patients about the law.

Partner notification is a complex issue. Some argue that partner notification statutes result in patients withholding information about partners. Although the name of the HIV-infected patient is not disclosed during partner notification, patients know that in many cases, it may be very easy for a partner to identify the individual responsible for his or her potential infection. Many HIV-infected patients may fear what the reaction of their partners will be. In a recent study, 45% of health care providers serving HIV-positive women reported that they had patients who feared partner notification because they were afraid of domestic violence, and one fourth of the providers reported having female patients that had actually been assaulted as a result of partner notification (Rothenberg, Paskey, Reuland, Zimmerman, & North, 1995). In a survey conducted by the National Association of People with AIDS (NAPWA), patients with AIDS ranked the threat of violence as a major concern. Seventeen percent of all women in the survey and a quarter of Latinas reported violence in the home (NAPWA, 1992). Domestic violence is very much an issue within the Latino community and can be fueled by cultural expectations related to the expression of *machismo* among men and *marianismo* among women.

It is important to be cognizant of the fact that many HIV-infected Latinas are infected as a result of their male partner’s infidelity with other women and/or men. These male partners may feel threatened by involuntary partner notification because they may not want to admit to their risky behavior or their sexual orientation. Issues of sex and drug

use should be discussed with the patient so that the provider can assess the likelihood of violence in the relationship and the dangers of partner notification without patient consent (North & Rothenberg, 1993). The development of a patient-provider relationship based on accurate information, *confianza*, and *respeto* will enable the provider to assist the patient to make the best decision for himself or herself. If there is a risk of violence to the patient, the health care provider should help the patient develop a safety plan.

Risks to Health Care Workers Treating HIV-Infected Patients

An epidemiological study conducted in 2001 identified a total of 57 HIV-infected health care workers who definitively contracted the virus occupationally (Do et al., 2003). Of the 57 health care workers, the majority (49) were exposed to HIV-infected blood, and 51 out of the 57 experienced percutaneous exposures (Do et al., 2003). Some of the major causes of the percutaneous injuries included unexpected movements by patients or coworkers, unsafe placement or disposal of sharp medical devices, and needle recapping. Several of these injuries could have been avoided if recommended precautions had been followed (Do et al., 2003).

CDC has adopted and updated universal infection-control precautions to prevent transmission of HIV and other blood-borne pathogens (CDC, 1987, 1988, 1989, 1990, 2001, 2003). It is important that all health care workers be aware of the importance of strict adherence to these procedures. Although high-risk encounters with HIV-infected patients are less likely to occur now than they were 10 or 20 years ago, the number of HIV-infected persons has dramatically increased, making health care providers much more likely to come into contact with HIV-infected patients (particularly in outpatient settings). Some health care providers may fear contact with HIV-infected patients despite the small amount of risk they face (National Minority AIDS Education and Training Center, 2002). Health care workers need to strive to always keep their patients' best interests in mind and confront and work to eliminate any unfounded fears that they or their peers may be facing, keeping in mind that the risk of occupationally contracting HIV is minimal. Health care providers have a clear ethical duty to effectively treat all patients, despite any personal fears of treating HIV/AIDS patients.

Risks to Patients from HIV-Infected Health Care Workers

As of December 2001, approximately 5% of all adult and adolescent AIDS cases were health care workers (Do et al., 2003). The risk of transmission from health care worker to patient is limited to those instances in which the worker is providing a service during which there is a potential for the patient to be exposed to the worker's bodily fluids. In this limited category, the risk of transmission from provider to patient is extremely small.

Many argue that the patient has the right to know about this potential risk as a part of informed consent and that the principle of beneficence, which requires the provider to act in the patient's best interest, means that the provider must inform the patient of his or her HIV/AIDS status. CDC recommended in 1991 that HIV-infected health care workers (specifically those that practice invasive procedures) be individually reviewed by a panel of experts to determine whether they may or may not continue performing these types of procedures and whether or not they should inform their patients of their seropositive status (Gostin, 2000).

Those who believe that the provider has no duty to inform the patient argue that mandatory disclosure (1) violates the health care provider's rights and privacy, (2) exposes the individual provider to potential loss of professional status and employment, and (3) may deter at-risk health care workers from getting tested and/or seeking treatment.

Ethical decision-making is always most difficult when the rights and interests of one group are opposed to the rights and interests of another group. In this case, however, it is the responsibility of the health care provider to make his or her patients' best interests a priority.

Clinical Research

Clinical researchers should include a sample of participants who are representative of the population to be treated. When clinical research participants are not representative of that population and when clinical research excludes (advertently or inadvertently) certain groups from clinical trials, there is a risk that the treatments developed will not benefit members of the excluded groups. This violates the ethical principle of justice.

Studies have shown that clinical research involving HIV-infected persons has not been representative of the overall population of HIV-infected individuals living in the United States. Data suggest that

Latinos and African Americans are less likely than Whites to participate in clinical trials.

Whites are overrepresented in HIV-related clinical research while Latinos and African Americans are underrepresented (Gifford et al., 2002). Data also suggest that HIV-infected Whites are more likely to have received experimental HIV medications when compared with their Latino and African American counterparts (Gifford et al., 2002). Even when controlling for patient characteristics, type of health insurance, socioeconomic status, level of education, and attitudes about health care, Latinos and African Americans are still significantly less likely than Whites to participate in clinical trials and receive experimental medication. Racial and ethnic disparities in access to new HIV treatments and clinical trial participation persist despite the National Institutes of Health's (NIH) guidelines aimed at increasing minority group participation in clinical trials (NIH, 1994). The failure to ensure inclusion of minority groups in clinical trials is a cause for serious concern because the biology, culture, social environment, and behavior of individuals in the excluded groups can all affect the course and progression of HIV as well as how individuals in the excluded groups respond to treatment regimens. The fact that HIV-infected persons are "four times as likely to be members of an underserved minority than to be white" compounds the ethical problem their exclusion poses (Gifford et al., 2002, p.1373).

To overcome these racial and ethnic disparities, providers should educate underserved Latino and African American HIV/AIDS patients about the benefits of participation in clinical trials, including the possibility of receiving new, experimental treatments as a result of participation. Providers should address common fears and misperceptions about clinical research in a culturally sensitive manner in order to build participation in clinical trials by HIV-infected minority patients. Health care organizations and providers should also work to ameliorate the problem of accessibility to research sites and other barriers.

Conclusion

Health care providers should strive to incorporate the ethical principles of autonomy, beneficence, non-maleficence and justice into the way they approach their work. Respect for the patient's right to make his or her own decisions, putting the patient's best interests first, endeavoring to "do no harm," and ensuring that patients are treated fairly are the hallmarks of good clinical practice. While it is clear that moral and ethical principles are necessary in the field of medicine, deciphering the correct decisions and paths to action is not always a simple task. Providers may face ethical challenges when their own beliefs and values interfere with their responsibility to treat

patients and/or to put their patients' interests before their own. The ethical principle of justice is imperative and must be maintained in all clinical and research settings. Latino patients infected with, or affected by, HIV/AIDS must be offered medical treatment that is culturally and linguistically appropriate, while simultaneously fostering the development of *confianza* and *respeto* between the patient and the provider.

References

- Centers for Disease Control and Prevention. (1987). Recommendations for prevention of HIV transmission in health-care settings. *MMWR*, 36 (Suppl. No. 2S), 1.
- Centers for Disease Control and Prevention. (1988). Update: Universal precaution for prevention of transmission of human immunodeficiency virus, hepatitis B virus, other bloodborne pathogens in health-care settings. *MMWR*, 37, 377-88.
- Centers for Disease Control and Prevention. (1989). Guidelines for prevention of transmission of human immunodeficiency virus and hepatitis B virus to health care and public-safety workers. *MMWR*, 38(no. S-6).
- Centers for Disease Control and Prevention. (1990). Public health service statement on management of occupational exposure to human immunodeficiency virus, including considerations regarding zidovudine postexposure use. *MMWR*, 39(RR01), 1-14.
- Centers for Disease Control and Prevention. (1997). *AIDS Alert, CDC defines good partner notification*, 12(1) (citing unpublished CDC handout).
- Centers for Disease Control and Prevention. (1999). Guidelines for national human immunodeficiency virus case surveillance, including monitoring for human immunodeficiency virus infection and acquired immunodeficiency syndrome. *MMWR*, 48 (13), 1-31.
- Centers for Disease Control and Prevention. (2001). Updated U.S. Public Health Service guidelines for the management of occupational exposures to HBV, HCV, and HIV and recommendations for postexposure prophylaxis. *MMWR*, 50(No. RR-11), 1-42.
- Centers for Disease Control and Prevention. (2003). Guidelines for infection control in dental health-care settings. *MMWR*, 52(RR-17), 1-61.
- Do, A.N., Ciesielski, C.A., Metler, R.P., Hammett, T.A., Li, J., & Fleming, P.L. (2003). Occupationally acquired human immunodeficiency virus (HIV) infection: National case surveillance data during 20 years of the HIV epidemic in the United States. *Infection Control and Hospital Epidemiology*, 24, 86-96.
- Gifford, A.L., Cunningham, W.E., Heslin, K.C., Andersen, R.M., Nakazono, T., Lieu, D.K., et al. (2002). Participation in research and access to experimental treatments by HIV-infected patients. *New England Journal of Medicine*, 346(18), 1373-82.
- Gostin, L. (2000). A proposed national policy on health care workers living with HIV/AIDS and other blood-borne pathogens. *Journal of the American Medical Association*, 284(15), 1965-70.

- Gostin, L., Ward, J., & Baker, A. (1997). National HIV case reporting for the United States. A defining moment in the history of the epidemic. *New England Journal of Medicine*, 337(16), 1162-7.
- Hertz-Picciotto, I., Lee, L., & Hoyo, C. (1996). HIV test-seeking before and after the restriction of anonymous testing in North Carolina. *American Journal of Public Health*, 86(10), 1446-50.
- Lo, B. (2000a). Confidentiality. In: *Resolving ethical dilemmas: A guide for clinicians*. Philadelphia: Lippincott, Williams & Wilkins.
- Lo, B. (2000b). Overview of conflicts of interest. In: *Resolving ethical dilemmas: A guide for clinicians* (2nd ed.). Philadelphia: Lippincott, Williams & Wilkins.
- National Association of People with AIDS. (1992). *HIV in America: A report by the National Association of People with AIDS*. Washington, DC: National Association of People with AIDS.
- National Institutes of Health. (1994). NIH guidelines on the inclusion of women and minorities as subjects in clinical research. *Federal Register*, 59(59), 14508-13.
- National Minority AIDS Education and Training Center. (2002). *BE SAFE: A cultural competency model for African Americans*. J. McNeil (Ed.), J. Campinha-Bacote, E. Tapscott, & G. Vample. Washington, DC: Howard University.
- North, R., & Rothenberg, K. (1993). Partner notification and the threat of domestic violence against women with HIV infection. *New England Journal of Medicine*, 329(16), 1194-6.
- Rothenberg, K.H., Paskey, S.J., Reuland, M.M., Zimmerman, S.I., & North, R.L. (1995). Domestic violence and partner notification: Implications for treatment and counseling of women with HIV. *Journal of the American Medical Women's Association*, 50(3-4), 87-93.
- San Francisco AIDS Foundation. (1998). *AIDS 101: Guide to HIV basics. HIV testing*. http://www.sfaf.org/aids101/hiv_testing.html

Sensitivity of the Provider

As the United States becomes increasingly diverse, it is even more critical for health care providers to address their own cultural competency, or lack thereof, when providing health care services to underserved populations. Certain racial and ethnic populations carry a disproportionate share of chronic disease burdens (e.g., HIV, diabetes, asthma) which are only further complicated by various barriers to care that include, but are not limited to, language, cultural differences, socioeconomic status, and health literacy (Blum, 2004). The 15-minute “one-size-fits-all” model of care in the United States is not well accepted by Latino patients who are accustomed to having plenty of time to talk to a health care provider who not only touches the patient but also may ask about the patient’s general health and personal and family status. A provider’s cultural competence can directly impact whether or not his or her Latino patients trust the provider and other health care workers, return for follow-up visits, follow prescribed treatments and/or medication, and encourage other family members to seek health care services.

When providers make an effort to deliver authentic, culturally competent care, they ensure that they are offering best practices for their patients. An understanding of cultural differences enhances the ability of health care professionals to make accurate health care diagnoses and appropriate referrals. Being aware of pertinent language issues can improve a provider’s ability to obtain informed consent from a patient with limited English proficiency. Patient satisfaction, trust, and confidence are increased when a provider is familiar with a patient’s previous health care experiences. Ultimately, cultural competence is indicative of a provider’s increased capacity to provide high quality care to HIV-infected Latino patients.

Unique Issues of Latinos and Health Care

Latinos have unique characteristics that make it difficult for them to seek and receive physical health and/or mental health services. As discussed in the Barriers to Care chapter, language can pose a serious problem for Latinos who are attempting to access and receive care. It is important for providers to remember that Spanish is not always the sole language for all Latinos; some populations are more comfortable speaking their indigenous languages, and others may prefer to speak English. Providers should always inquire as to their patient’s preferred language and then adapt or modify verbal interaction accordingly.

There is a vast range of educational experiences among Latinos in the United States. Some Latinos may speak only Spanish or an indigenous language, while others may be proficient in several languages and hold high level professional degrees. Providers should be aware that a substantial number of Latinos have not been afforded the privilege of higher education and have low literacy levels in Spanish and/or English. Due to the stigma related to illiteracy, patients may feign eyesight problems because of their inability to read. Providers should be sensitive to this barrier and assist the patient by reading the information and asking questions in a friendly manner to ensure patient comprehension.

Providers who are fluent in their patient's preferred language must also remember that while they may be able to effectively communicate in the patient's language, they may use medical terminology that, regardless of language, is unfamiliar to the patient. When attempting to communicate with a Latino patient, with or without an interpreter, health care providers should use plain language and emphasize and repeat key points to ensure patient comprehension (Picker Institute, 2000).

Health care workers must work to dispel common stereotypes and assumptions when working with Latino patients. They must also acknowledge the heterogeneity of Latinos. Latinos come from many different geographic regions, including the Caribbean and South, Central, and North America. Each of these regions has different cultures, language nuances, and health care traditions. Providers should not assume that because in one country the patient may use the services of a *curandero* (folk healer) that individuals from another Latin American country would do the same. Countries of origin can affect cultural values of Latino patients, as can levels of acculturation. The range in level of acculturation often depends on the number of years the individual has been in the United States, the amount of time spent in the educational system, and the individual's ability to speak English.

Another factor that can affect the patient-provider relationship is the amount of previous experience the Latino patient has with health care providers in the United States. In some cases the patient may be seeing a U.S. medical professional for the first time, which can be intimidating, and depending on this experience, may result in a distrust of the health care system. Typically, Latino patients are accustomed to having providers in Latin American countries touch them, spend more time with them, and discuss personal issues beyond health care (e.g., family, personal life). In addition, patients in Latin American countries often sit and converse with the doctor about the

medical problems being addressed prior to being seen in the examining room. Patients may not communicate health or personal issues at the first meeting with a U.S. provider because they may not trust the provider. If patients are undocumented, they may be wary of sharing information for fear of being reported to the government and/or deported. Providers need to develop relationships with patients and work to build trust that will, in turn, facilitate comfort and communication and allow for the sharing of personal health information.

Definition and Stages of Cultural Competency

Holland and Courtney (1998) define cultural competence as:

... an openness to cultural differences. The acceptance of ethnic differences in an open, genuine manner, without condescension and without patronizing gestures, is critical for the development of an ethnically competent professional style... Systematic learning depends on whether the worker-as-help-provider is willing to adopt the role of worker-as-learner. (p. 46)

The concept of “worker-as-learner” is also validated by Campinha-Bacote (1998) and Purnell and Paulanka (1998) in their identification of four stages of cultural competence that directly relate to the health care professional’s level of sensitivity or “consciousness” regarding interactions with patients from diverse cultural or ethnic groups.

Stage 1: *Unconscious incompetence*, in which the health care professional is not aware that cultural differences exist; essentially, he or she is “culturally blind.” Examples of cultural blindness are demonstrated through the common assumptions made by some providers that all Latino patients come from the same country (e.g., Mexico, El Salvador, or Cuba), eat tortillas, speak only Spanish, and/or lack documentation. These faulty assumptions disregard the concept of intra-ethnic variation (in some instances, cultures vary more within ethnic groups than across ethnic groups).

Stage 2: *Conscious incompetence* is being aware that one is lacking knowledge about another culture and realizing that cultural differences do exist. For example, a social worker may recognize that her Latino patient has different beliefs and values than she; however, the social worker has no interest in learning about the patient’s beliefs/values in order to increase her capacity to care for the patient.

Levels of Consciousness:

1. Unconscious in competence
2. Conscious incompetence
3. Conscious competence
4. Unconscious competence

Stage 3: *Conscious competence* is the conscious act of learning about a patient's culture, verifying generalizations, and providing culturally relevant interventions. An example of conscious competence would be a psychologist researching some unfamiliar cultural terms and concepts that he has heard his Latino patient make reference to during their clinical sessions in order to learn more about his patient's culture.

Stage 4: *Unconscious competence* occurs when the health care professional clearly demonstrates the ability to automatically provide culturally congruent services to patients from a diverse cultural group. For example, a non-Latino physician who has considerable experience in working with the Latino population may have the inherent knowledge to use cultural expressions and appropriate communication strategies without being conscious of the fact that these are not within the physician's original cultural framework.

Provider Self-Awareness

It can be difficult for a health care provider to question his or her lack of cultural competency when dealing with the Latino population. However, a basic step to addressing whether a provider is or is not culturally competent is to conduct a self-assessment of biases, experiences, and knowledge of one's own culture(s). Providers should ask themselves how and in what ways they value their own culture(s), whether they think about culture in general, and how they value the culture(s) of others (Chin, 1999). While this appears to be a very simplistic first step, it does allow the provider to do some initial reflection on the challenges of becoming culturally competent. It also may engender the provider's appreciation for the experiences that a patient outside the dominant mainstream culture may have had to endure.

Several tools exist for providers to assess their cultural competence/sensitivity. Most of these tools will ask providers to evaluate their own cultural sensitivity by assessing the following:

- **Personal values and attitudes**—including those practices that promote mutual respect between health care professionals and patients (e.g., screening materials for offensive cultural ethnic or racial stereotypes, being aware of when it is appropriate to intervene on behalf of patients when providers/organizations display culturally insensitive behaviors).
- **Communication styles**—including optimal use of translators and alternatives to written communications (particularly for patients who are not English proficient or lack literacy skills).

- **Community participation**—being aware of issues and concerns in the community of the patients being served and working with appropriate community institutions and/or organizations to develop and implement programs that will ameliorate these problems.
- **Learning environments**—establishing and being committed to providing opportunities for organizational staff to participate in cultural learning experiences. These could include language classes, multicultural learning groups, inter-cultural organization staff exchanges, and the hiring of bilingual and bicultural staff who can share their knowledge and skills besides assisting in the organization's evolution in meeting the needs of diverse communities.
- **Policies and procedures**—including written policies, mission statements, goals, and objectives for cultural and linguistic philosophies and practices. Policies and procedures must have strict guidelines for enforcement.
- **Patient-sensitive clinical practice**—developing a practice that avoids misusing scientific information and stereotyping group members, while acknowledging the importance of culture. Events that commemorate the diverse cultures served need to be held to further the education of staff and health care workers involved in patient care. It is not uncommon for cultural events to be centered on the ethnic foods of a given population (for example, serving tacos to celebrate a Mexican holiday or event). When done in isolation, this can be a very limiting and ethnocentrically comfortable way to interpret another culture, and thus should either be avoided or supplemented with some form of accurate knowledge dispersal.
- **Training and professional development**—including cultural competency training opportunities for health care professionals and staff, as well as making colleagues aware of the implications of cultural competency for enriching patient-provider interactions and increasing positive patient outcomes.

Conclusion

Health care professionals will be more effective in providing culturally sensitive care to Latino patients with HIV/AIDS if they: **(1)** have a good knowledge and understanding of their own cultural beliefs and values; **(2)** understand the different nuances of the different Latino communities with which they work; **(3)** have knowledge of the sociopolitical influences and/or barriers to care that the various Latino communities face; and **(4)** are committed to developing the skills and knowledge needed to work with culturally diverse groups of Latinos (National Minority AIDS Education and Training Center, 2002).

Resources

The following websites provide several resources on cultural competence including journal articles, self-assessments, and organizational benchmarks.

- The California Endowment (<http://www.calendow.org>) provides resource manuals on cultural competency for health care professionals.
- U.S. Department of Health and Human Services, Office of Minority Health. The Center for Linguistic and Cultural Competence in Health Care (<http://www.omhrc.gov/cultural/>) provides resources on standards for culturally and linguistically appropriate health services.
- The National Center for Cultural Competence, Georgetown University (<http://gucdc.georgetown.edu/nccc>) provides general resources for cultural competency.
- Cross-Cultural Health Care Program (<http://www.xculture.org>) is a resource site on cross-cultural competency.
- American Medical Association (<http://www.ama-assn.org>) provides a variety of journal articles and other resources.
- Diversity Rx (<http://www.diversityrx.org>) is a clearinghouse of information on language and cultural needs of diverse populations seeking health care.
- The Commonwealth Fund (<http://www.cmwf.org>) provides cultural competency resources, approaches, and frameworks.
- The National Alliance for Hispanic Health (<http://www.hispanichealth.org>) provides guidance for cultural proficiency.

References

- Blum, E. (2004). *Zero tolerance for disparity begins with primary care*. Washington, DC: American Medical Association.
- Camphina-Bacote, J. (1998). *The process of cultural competence in the delivery of healthcare services: A culturally competent model of care* (3rd ed.). Cincinnati, OH: Transcultural C.A.R.E. Associates.
- Chin, J.L. (1999). Cultural competence in a multicultural society: A checklist. *Self Help Magazine*: www.selfhelpmagazine.com.
- Holland, L., & Courtney, R. (1998). Increasing cultural competence with the Latino community. *Journal of Community Health Nursing*, 15(1), 45-53.
- National Minority AIDS Education and Training Center. (2002). *BE SAFE: A cultural competency model for African Americans*. J. McNeil (Ed.), J. Campinha Bacote, E. Tapscott, & G. Vample. Washington, DC: Howard University.
- Picker Institute. (2000). Cultural factors in patient care. *New Visions for Health Care* (Bulletin), 21, 1.
- Purnell, L., & Paulanka, B. (1998). *Transcultural health care: A culturally competent approach*. Philadelphia: F.A. Davis, Co.

Assessment

Cultural assessment is defined as the ability of health care professionals to collect relevant data regarding the patient's presenting problems and health history in the context of the patient's culture (Campinha-Bacote, 1998). The basic premise of a cultural assessment is that patients have a right to their cultural beliefs, values, and practices, and that these factors should be respected, understood, and considered when rendering culturally competent care (Leininger, 1978). Understanding and negotiating with patients about the many social and cultural factors that influence their care can improve treatment outcomes and foster greater patient satisfaction.

Patients have a right to their cultural beliefs, values, and practices. Understanding these factors and negotiating with patients about them can improve the patient's treatment outcomes and increase patient satisfaction.

Culturally Based Assessments and Treatment Plans

Culturally based assessments and treatment plans are especially appropriate in treating Latinos with HIV/AIDS. Leininger (1978) defines a cultural assessment as a "systematic appraisal or examination of individuals, groups, and communities as to their cultural beliefs, values, and practices to determine explicit needs and intervention practices within the cultural context of the people being evaluated." Several user-friendly cultural assessment tools using a mnemonic format have been created to assist health care professionals in eliciting valuable data from patients (Berlin & Fowkes, 1983; Stuart & Lieberman, 1993; Like, 1997). These mnemonic models are represented by the acronyms **BATHE**, **ETHNIC**, and **LEARN**, and will be described in the following pages.

BATHE

BATHE stands for: **Background, Affect, Trouble, Handling, and Empathy**. The **BATHE** model (Stuart & Lieberman, 1993) can be used for eliciting information regarding the patient's psychosocial context. The health care professional first inquires about the patient's **background** by asking questions such as "What is going on in your life?" This question assists in eliciting the context of the patient's visit. Assessing the **affect** of the patient is equally important. Asking the question, "How do you feel about what's going on?" can assist the health care professional to assess the patient's mood and allows the patient to report and label how he or she currently feels. The health care professional also must assess the possible symbolic significance

of the illness. A question such as, “What about the situation troubles you the most?” will elicit information in this area. It is also important to assess the patient’s functioning level. Asking the question, “How are you handling your illness?” will give the health care professional insight into the patient’s capacity to cope and provide direction for intervention. Finally, the health care professional must be empathetic during the assessment phase of care. Commenting that, “It must be very difficult for you . . .” legitimizes the patient’s feelings and provides psychological support.

ETHNIC

The **ETHNIC** model—**Explanation, Treatment, Healers, Negotiate, Intervention, and Collaboration**—is a user-friendly framework for culturally competent clinical practice. Like (1997) states, “To become culturally competent is to be culturally humble . . . clinicians need to learn what questions to ask to elicit the patient’s cultural framework—how patients explain their illness and what they expect, perhaps unconsciously, from a visit to a physician.”

Like asserts that the health care professional must elicit the patient’s **explanation** of his or her problem. He suggests asking questions to ascertain the patient’s perception of his or her illness, such as:

- “Why do you think you have these symptoms?”
- “What do friends, family, and others say about these symptoms?”
- “Do you know anyone else who has had or who has this kind of problem?”
- “What have you heard about/read/seen on TV/radio/newspaper concerning your illness?”

Health care professionals must assess the types of **treatment** that patients have received for their illnesses, particularly due to the diverse clinical manifestations that encompass an HIV/AIDS diagnosis. Questions such as, “What kinds of medicines, home remedies, or other treatments have you tried for this illness?” or “Is there anything you eat, drink, or do (or avoid) on a regular basis to stay healthy?” will assist health care professionals in collecting these data. Some patients may be receiving care from alternative health care professionals and healers. Asking questions such as “Have you sought any advice from alternative or folk **healers**, friends, or other people who are not doctors for help with your problems?” will clarify the use of nontraditional health care professionals. This is of particular significance when working with the Latino population due to the frequent use of alternative medical practices.

Negotiation of a mutually acceptable treatment plan is of great importance for adherence to a prescribed HIV related regimen. The health care professional must try to find treatment options that will be mutually acceptable to both the health care professional and to the patient and that do not contradict, but rather, incorporate patient beliefs. The health care professional must then determine an **intervention** with the patient, which may incorporate alternative treatments, spirituality, and healers, as well as other cultural practices (e.g., foods eaten or avoided in general and/or when sick). Finally, the health care professional collaborates with the patient, family members, other health care team members, healers, and community resources to make possible the most optimal and holistic treatment regimen available for the HIV-infected Latino patient.

LEARN

The LEARN guidelines—**Listen, Explain, Acknowledge, Recommend, and Negotiate**—were used by Berlin and Fowkes (1983) when conducting a cultural assessment.

- **Listen:** The first step is to listen to the patient’s perception of his or her presenting problem.
- **Explain:** The second step involves the provider’s explanation of his or her perception of the problem, including the problem’s physiological, psychological, spiritual, or cultural causations and/or manifestations.
- **Acknowledge:** The next step involves the acknowledgement of the similarities and differences between the perceptions of the patient and the provider. While it is important to acknowledge differences in perceptions, the health care professional should emphasize the similarities and use them as a bridge for culturally relevant communication on which confianza (trust) can be built.
- **Recommend:** The fourth step involves the provider’s recommendations for treatment. It is essential that the patient has an active role in the adaptation of these recommendations as they are written into the Latino patient’s medical care plan.
- **Negotiate:** Finally, the health care professional should negotiate a treatment plan, considering that it is beneficial to incorporate selected aspects of the patient’s culture in the plan so as to ensure culturally competent care and positive patient outcomes.

EXPLANATORY MODEL

Kleinman (1980) offers health care professionals a cultural assessment tool that is based on the patient's perception of the illness, which is referred to as the Explanatory Model. Kleinman makes a clear distinction between two aspects of sickness: disease and illness.

Disease refers to malfunctioning of biological and/or psychological processes, while the term illness refers to the psychological experience and meaning of perceived disease. . . . It is created by personal, social and cultural reactions to disease. That is, illness contains responses to disease which attempt to provide it with a meaningful form and explanation as well as control. . . . Viewed from this perspective, illness is the shaping of disease into behavior and experience. (p.74)

Explanatory models of patients can be elicited in all clinical settings if health care professionals are persistent and demonstrate a genuine, nonjudgmental interest in patients' beliefs. In addition, health care professionals must express the conviction to patients that knowledge of their Explanatory Model is important to planning an appropriate treatment (Kleinman, 1980). Kleinman, Eisenburg, and Good (1978) suggest the following eight open-ended questions when assessing the patient's Explanatory Model:

1. What do you think has caused your problem?
2. Why do you think it started when it did?
3. What do you think your sickness does to you?
4. How severe is your sickness?
5. What kind of treatment do you think you should receive?
6. What are the most important results you hope to achieve from this treatment?
7. What are the chief problems your sickness has caused?
8. What do you fear most about your sickness?

When conducting a cultural assessment among Latino patients with HIV/AIDS, responses to these questions will play a significant role in developing a culturally responsive treatment plan. This significance is demonstrated in the following case study.

Case Study

Robert Martinez, a 26-year-old patient of Puerto Rican descent diagnosed with AIDS, presents at an outpatient clinic for management of his condition. Mr. Martinez was initially seen by a social worker. After engaging in an introductory conversation with the patient, the social worker obtained a social history assessment by integrating Kleinman's eight cultural questions. When asked what he thought caused his illness, Mr. Martinez readily explained, "I lost favor with the saints. I was exposed to the virus through a friend who shared drugs with me, and because I was not worshiping God and the saints properly, I got infected. They (the saints) would have protected me from this disease if I had been in their favor."

When asked why Mr. Martinez thought he got AIDS when he did, he responded, "I really don't know. I didn't know I was seropositive until some years into my illness. In fact, it was when I decided to straighten out my life and stop shooting up that I found out about my diagnosis of AIDS." Mr. Martinez was then asked what he thought AIDS does to him. He stated that it has enhanced his relationship with God and the saints. He added, "It makes me want to live my life the right way."

The social worker then asked how severe Mr. Martinez thought his sickness was. He stated that, at times, he becomes angry and afraid because he doesn't know what's going to happen next and he is afraid his condition will get worse. He added, "I try to focus on my relationship with God and the saints to heal this illness and to ward off evil spirits." The social worker then asked what kind of treatments Mr. Martinez thought he should receive. Mr. Martinez stated that he had a strong belief in *Santeria* as well as a belief in good and evil spirits. He suggested that reciting spiritualist prayers in conjunction with the use of special oils, incense, lotions, and herbs would likely improve his condition. He reported that a distant relative once was cured of cancer after preparing a feast and offerings for one of the patron saints, and that this may be something for him to try, as well.

When asked what he hoped to achieve from these treatments, Mr. Martinez stated that he hoped to have physical relief, spiritual relief (enlightenment and salvation), and protection from evil. He further explained that by finding favor with the saints, it is possible that they may cure him of his illness altogether. Mr. Martinez also reported the chief problem in having AIDS was feeling depressed. When the social worker asked Mr. Martinez what he feared most about his illness, he responded, “I am afraid that I may suffer a lot before I die.”

This case study clearly demonstrates the valuable information that can be gained by conducting a cultural assessment using Kleinman’s eight questions. In this case, the social worker should be aware that by using folk healing practices (e.g., herbs and oils); Mr. Martinez may be achieving a sense of control over a very uncertain illness. The use of folk healing can be considered an active coping process, and active coping styles have been shown to have positive psychological and physical outcomes (Suarez, Raffaelli, & O’Leary, 1996). For this reason, the social worker should view Mr. Martinez’s treatment ideas as having a potentially beneficial role in the improvement of his health outcomes and should recommend that his ideas be integrated into his treatment regimen. In formulating a culturally responsive treatment plan for Mr. Martinez, it is important for the social worker to incorporate a mutually agreeable plan that includes:

1. Mr. Martinez’s belief in *Santeria*
2. The use of spiritualist prayers, oils, incense, lotions, and herbs
3. Increasing his knowledge base of antiretroviral medications
4. Acknowledging his spiritual beliefs
5. Identifying strategies to manage his depression
6. Providing culturally specific approaches (i.e., spirituality) to cope with his anger and fear
7. Further discussion and exploration of his fear of pain and suffering
8. Offering him hope in his quest to maintain a positive and healthy life

Integration of Cultural Content

It is important for health care professionals to keep in mind that conducting a cultural assessment is more than merely selecting the “right tool” and asking the patient the questions listed on the tool. The cultural assessment must be conducted in a culturally sensitive manner. One approach is for health care professionals to integrate cultural content into their existing assessment instruments. In contrast to having a separate cultural assessment tool or form, health care professionals may find it more helpful to revise their existing health history or assessment form to reflect culturally relevant questions (Campinha-Bacote, 1995). If a cultural assessment is conducted in this manner, culture is not singled out; rather, it is appropriately incorporated into the patient’s overall assessment.

Buchwald et al. (1994) suggest other techniques for eliciting cultural content from the patient in a culturally sensitive fashion. First, health care professionals must listen with interest and remain nonjudgmental about what they hear. Some patients may openly share information about their lifestyles and behaviors that may sound shocking to the health care professional. To gain relevant information about the patient’s lifestyle that may affect treatment, the health care professional must continue to remain nonjudgmental and listen with genuine interest. Second, the health care professional may want to develop alternative styles of inquiry by adopting a less direct and more conversational approach to assessing the patient’s background. Health care professionals may consider conversational remarks such as, “Tell me about yourself and your family.” Another technique is to frame questions in the context of other patients or the patient’s family. For example, “I know a patient who believes _____ about AIDS. Do you think that?” or “What does your mother think about AIDS?” Attributing explanations to another person can help patients disclose health beliefs and practices that they may feel uncomfortable expressing directly (Buchwald et al., 1994). These strategies are of particular relevance to Latino communities, wherein numerous myths regarding HIV transmission and causation currently exist.

Conclusion

Data obtained from a cultural assessment will assist health care professionals in formulating a mutually acceptable and culturally responsive treatment plan for their Latino patients. Although it is critical to conduct cultural assessments on ethnically diverse patient populations such as Latinos, cultural assessments should not be limited only to these patients. It is important to realize that “every patient

Every patient needs a cultural assessment.

needs a cultural assessment; not patients who look like they need a culturally based assessment” (Campinha-Bacote, 1995). Providers must be wary of relying on perceptions based on appearance to explain a patient’s culture and background, particularly among Latinos wherein diverse admixtures of all races and ethnicities are represented. All patients have values, beliefs, and practices that must be considered and incorporated in the assessment, planning, and implementation of health care services. Conducting a cultural assessment on all patients will prevent “cultural blind spot syndrome,” which occurs when health care professionals assume that there are no cultural differences or potential barriers to care because the patient looks and behaves much the same way they do (Buchwald et al., 1994).

References

- Berlin, E., & Fowkes, W. (1983). A teaching framework for cross-cultural health care. *Western Journal of Medicine, 139*, 934-48.
- Buchwald, D., Caralis, P.V., Gany, F., Hardt, E.T., Johnson, T.M., Muech, M.A., et al. (1994). Caring for patients in a multicultural society. *Patient Care, 28*, 105-23.
- Campinha-Bacote, J. (1995). The quest for cultural competence in nursing care. *Nursing Forum, 30*, 19-25.
- Campinha-Bacote, J. (1998). *The process of cultural competence in the delivery of health care services* (3rd ed.). Cincinnati, OH: Transcultural C.A.R.E. Associates.
- Kleinman, A. (1980). *Patients and healers in the context of culture*. Los Angeles, CA: University of California Press.
- Kleinman, A., Eisenburg, L., & Good, B. (1978). Culture, illness and care. *Annals of Internal Medicine, 116*, 256.
- Leininger, M. (1978). *Transcultural nursing: Concepts, theories, research and practices*. (2nd ed.). New York: McGraw Hill.
- Like, R. (1997). *Becoming culturally competent*. Newark, NJ: Center for Healthy Families and Cultural Diversity, Department of Family Medicine, UMDNJ-Robert Wood Johnson Medical School.
- Stuart, M.R., & Lieberman, J.R. (1993). *The fifteen-minute hour: Applied psychotherapy for the primary care physician* (2nd ed.). New York: Praeger.
- Suarez, M., Raffaelli, M., & O’Leary, A. (1996). Use of folk healing practices by HIV-infected Hispanics living in the United States. *AIDS Care, 8*(6), 683-90.

Facts

Latinos living with HIV/AIDS comprise a diverse population with a variety of needs. Awareness of the important cultural beliefs and values of the Latino population is critical for effective care and treatment of the Latino patient. While certain values and beliefs may not apply to all Latino patients, it is essential that providers be aware of general cultural influences. Providers must also be knowledgeable of disparities affecting the Latino population and biological variations in the manifestation of HIV.

Cultural Beliefs and Values

When providing medical care to a Latino patient, it is helpful for the provider to be familiar with the terms *fatalismo*, *familismo*, *simpatia*, *confianza* and *respeto*, and to understand the ways in which these terms can affect the clinic visit. *Fatalismo* is the belief that one must passively accept the unfortunate events in one's life and the belief that one has little control over negative health outcomes. This belief is sometimes found among Latinos, particularly immigrants who have suffered a great deal of hardship. Although research efforts have related *fatalismo* to misconceptions about cancer and its diagnosis, further investigation is greatly needed to determine the effects of fatalismo on HIV prevention behaviors among Latinos in general, as well as adherence to medical regimens among those with HIV (Morgan, Park, & Cortes, 1995). It is imperative that the provider work with the patient to facilitate empowerment and create opportunities for participation in treatment and wellness related behaviors, thus enabling a sense of control over the virus and its progression.

Familismo is related to the reliance of the individual on the family network for social support. *Familismo* is often found among patients with other serious illnesses and to a lesser extent among those with HIV. Due to the high degree of stigma associated with HIV infection, many Latinos, particularly those who have been infected through homosexual contact and/or Intravenous Drug Users (IDU). IDU are often reluctant to share their medical condition with family members due to fear of rejection. Other Latinos infected with HIV find considerable support within their family structure. Incorporation of the family into treatment can be an important element of treatment adherence. A strong family support system can help lead to a successful treatment and HIV management process. Families are usually large and extended, and may accompany ill family members to the medical visit. Providers should remember that the

Latino family is a core aspect of medical decision-making and plays an important role in the recovery phase (Abraido-Lanza, Dohrenwend, Ng-Mak, & Turner, 1999; Stycos, 1952). Providers must begin to see the many visitors who often surround a Latino patient's bedside as a positive element, as opposed to a nuisance and disruption to the busy health care environment.

Simpatia is the quality of being friendly with an edge of humility and vulnerability. It is an important trait among Latinos and it is a quality that Latinos expect to find in health care providers. A provider who is boastful or arrogant will not gain the trust of the patient. The existence of *confianza* (trust) is perhaps the most critical element within a positive patient-provider relationship. If a provider is able to gain *confianza*, a patient will be much more likely to fully adhere to a medical regimen, communicate questions and concerns, and attend regular visits. Due to the fact that the development of *confianza* within a relationship takes a considerable amount of time, which the U.S. medical delivery system often does not allow, it may prove very difficult for the provider to develop *confianza*, particularly when the provider may not speak the patient's language. However, a strong and trusting bond can be formed between the patient and the provider with consistent openness, friendliness, and expressions of sincere concern for the patient.

Respeto is the ability of a provider to reciprocate respect for the patient. *Respeto* is of vital importance in the era of HIV and AIDS, particularly given the substantial stigma HIV and AIDS elicit within the Latino community. Providers must acknowledge that Latinos often experience a great deal of discrimination. A provider's office should be a place where Latinos infected with HIV can expect to feel invited, well cared for, and respected at all times. Religion and spirituality are also important sources of support for the Latino patient and may influence health. Although a growing number of Latinos are Christian and may participate in the Evangelical movement, the vast majority practices Catholicism. With Latinos of many religious affiliations, prayer is viewed as adjunct to medical care. Attending religious services has also been linked to a protective effect on mortality for some Catholics (Oman & Red, 1996). Arranging for last rites or the Anointing of the Sick is something that can be very important for an ill or dying Catholic patient. Providers should be sensitive to these religious beliefs.

Gender Roles

Gender roles are well defined in the Latino population. *Marianismo* is the term used to define the most frequently prescribed gender role of the Latina. *Marianismo* encompasses the qualities of chastity, virginity, abnegation (self-denial), and sacredness. Devotion to home and family and self-sacrifice in the interests of the family are also necessary aspects of *marianismo* (Gil & Inoa-Vazquez, 1996). According to *marianismo*, women are expected to accept their fate as mothers and wives and be willing to endure any necessary suffering for the good of the family. Female virginity in unmarried women and motherhood in married women are two aspects of *marianismo* that are highly valued (Bigby, 2002). Latino men traditionally are characterized by *machismo*, which refers to providence, virility, sexual prowess, strength, independence, bravery, and sometimes complete decision-making power within the family. *Machismo* also involves demonstrating love and affection for the family and protecting them from harm. The male is expected to protect the family's reputation, which may include defending and protecting the sexual morality of the female members of the family (Ramirez, 1993). It is important for health care providers to remember that the terms *marianismo* and *machismo* can have distinct connotations for different individuals and can hold both positive and negative attributes. Providers should remember that in some cases these cultural values may have little or no influence on Latino patients and that more highly acculturated Latinos might not possess these cultural mores.

Use of Folk Medicine

Much of the folk medicine that is practiced within Latino and Caribbean communities is sought after by immigrant populations who may have had little experience with Western medical systems within the U.S. Throughout Latin America and the Caribbean, herbal and spiritual remedies can be purchased in *boticas*, *botanicas*, or *farmacias*. It is important for the provider to understand that pharmacies throughout Latin America and the Caribbean often sell homeopathic remedies and Western medical prescriptions in equal amounts. It is not uncommon for a pharmacy to be divided in half, with one half offering Western medical supplies and medicines, and the other half providing homeopathic and herbal alternatives. In addition, the pharmacist often serves the role of medical doctor and may diagnose an illness and/or prescribe the suitable treatment for the client. In the United States, many of these practices are utilized in similar settings established by immigrant Latinos. Many people involved in folk

medicine, such as *sobadores* (masseuse or masseur) or *curanderos* (folk healers), are also sought for their ability to treat illnesses or aches. Furthermore, house calls from *sobadores* and *curanderos* are not an uncommon phenomenon within the Latino community.

Many Latino populations, particularly immigrants, believe strongly in the impact that spiritual or emotional events can have on health status (Landrine & Klonoff, 1994). For this reason, *limpias* (spiritual cleansings) and practices related to *espiritismo* (spiritism) are not uncommon. Caribbean immigrants may also practice *Santeria* (a combination of the Yoruba religion with Catholicism) and may seek care and advice in *botanicas*.

As opposed to comparing the belief or use of folk medicine with his or her outlook, it is preferable for a provider to gather as much information as possible and to then consider the health impact of the treatment in which the patient is engaged. The level of provider knowledge regarding the many ethnomedical practices used within the Latino community can improve the patient's level of trust in the provider and adherence to health care regimens (Murguia, Peterson, & Zea, 2003). It is critical to recognize that *curanderos*, *sobadores*, *santeros* and *espiritistas* are often much-respected members of the community who are recognized for their ability to treat culturally bound ailments, such as *mal de ojo* (evil eye), *empacho* (gastrointestinal obstruction), or *susto* (fright sickness) (Murguia et al., 2003). Furthermore, a provider who discourages or demonstrates negative bias toward ethnomedical practices may further isolate a patient and actually have a negative impact on his or her ability to access care. The polarization of the two types of medicine promotes an environment wherein many Latinos with serious illness may delay treatment until the illness has had grave effects on their health.

The integration of ethnomedical practices into a patient's treatment regimen has the potential to make the difference between a patient's willingness to adhere to medical regimens or complete rejection and fear of medicines and their side effects. Research regarding the synergistic physiological and psychological effects of ethnomedical approaches integrated with Western medicine is gravely lacking. The opportunities for integration of ethnomedical practices are endless and may, in fact, result in highly positive outcomes. For example, a *limpia* (spiritual cleansing) or a *soba* (massage) is unlikely to incur any medical harm to a patient. If perceived as beneficial by the patient, these treatments could be incorporated into a treatment regimen with favorable results. Knowing the extent to which a positive psychological outlook can have on the immune functioning of HIV-positive patients,

potential benefits should be weighed prior to advising the discontinuation of any folk medicine practices. An integration of the two forms of medicine may provide a sense of social support and comfort to an immigrant who is HIV-infected and who is struggling to adapt to the United States in addition to this new diagnosis of HIV.

Some providers may have a sense of trepidation regarding the integration of unfamiliar ethnomedical practices due to the potential harm they may cause a patient. Although most practices appear to be safe, such as massage, it is important that the provider has knowledge of the few remedies that have been proven harmful, such as those that contain lead or mercury. Research has shown that folk remedies designated to treat *empacho* (gastrointestinal obstruction) using *greta*, *azarcon*, or *albayalde* can be extremely toxic due to high lead oxide concentrations (Flores, 2000; Mikhail, 1994). In addition, botanicas found in some Latino and Caribbean communities have been found to sell *azogue* (metallic mercury) as a remedy that often results in neurological disorders (Wendroff, 1990). It is advantageous for the provider to be aware of the patient's folk medicine practices so that he or she may integrate harmless practices into the patient's treatment regimen. The provider may also advise the patient of any harmful consequences that could result from the few dangerous practices that are known to exist.

HIV/AIDS Disparities

Latinos with AIDS tend to be tested and diagnosed later and die more quickly (within 1 year of diagnosis) of AIDS than Whites (Centers for Disease Control and Prevention [CDC], 2003b; Neal & Fleming, 2002). HIV was the fourth leading cause of death for Latinos ages 25-44 in 2000 (CDC, 2003a). In 2001, the rate for AIDS cases among Latino adults/adolescents was more than three times higher than among Whites, and the incidence of AIDS in Latino children was substantially higher than in White children (CDC, 2001b). Latinas currently represent one of the fastest growing populations with AIDS in the United States, with their AIDS case rate being five times higher than that of White women in 2001 (CDC, 2001b). Newly reported AIDS cases for Whites and Latinos in 2001 demonstrate that women represent 23% of cases overall among Latinos, compared with 15% of cases among Whites (CDC, 2001a).

AIDS cases among Latinos vary by place of birth. Latinos born in the United States accounted for 43% of AIDS cases reported among Latinos, followed by Latinos born in Puerto Rico (22%), and those born in Mexico (14%). HIV transmission patterns among

Latinas represent one of the fastest growing AIDS populations.

Latinos also vary by place of birth: Age-adjusted death rates per 100,000 standard population are 32.5 among mainland Puerto Ricans, 20 among the Commonwealth of Puerto Rico, 8 among Cubans, 4 among Mexicans, and 6 among other Latino groups (CDC, 2001b). Although AIDS cases were initially found primarily among the Puerto Rican population, subpopulation and geographic shifts are occurring. Among Latino immigrants, those born in Mexico were the only group to experience increases in new AIDS diagnoses, with cases doubling from 7% in 1992 to 14% in 2001, indicating a dramatic rise in HIV among this subpopulation (National Alliance of State and Territorial AIDS Directors, 2003). Although AIDS cases among Latinos have been reported in every State, the impact of the epidemic on Latinos is not uniformly distributed across the country. AIDS case rates per 100,000 among Latinos are highest in the eastern part of the U.S., particularly in the Northeast (CDC, 2000). Estimated AIDS prevalence among Latinos is clustered in a handful of States, with nine States and Puerto Rico accounting for 90% of Latinos estimated to be living with AIDS (New York, California, Florida, Texas, New Jersey, Pennsylvania, Massachusetts, Connecticut, and Illinois) (CDC, 2001b).

Modes of exposure to HIV also differ by gender, race, and ethnicity. Among White men with AIDS, 73% were exposed through men who have sex with men (MSM), 13% through Intravenous Drug Users (IDU), 7% through MSM/IDU, 5% through heterosexual contact, and 1% with risk unidentified. Among Latino males, these statistics vary considerably with 48% having been exposed through MSM, 29% through IDU, 5% through MSM/IDU, 16% through heterosexual contact, and 1% with risk unidentified (CDC, 2001). White and Latinas also demonstrate differences in modes of HIV exposure. Whereas heterosexual contact accounts for 59% of exposures among White women, 65% of Latinas are infected via heterosexual contact. Injection drug use accounts for 38% of exposures among White women and 32% of infections among Latinas (CDC, 2001b). Injection drug use is more common among Puerto Ricans than other Latino subgroups, and this may be linked to higher HIV rates in this subgroup (Klevens, Diaz, Fleming, Mays, & Frey, 1999). Due to variations in exposure patterns, patient education may need to be tailored to meet the HIV prevention requirements of various Latino subgroups.

It is critical for health care providers to counsel patients on preventive measures, treatment options, and appropriate referrals for support while using a culturally appropriate approach. In the HIV/AIDS literature, cultural variables are most often framed as barriers to risk-reduction behaviors (Marin, 1996). One possible reason for higher incidence and mortality of HIV/AIDS among Latinos may be related to

less access to accurate information. Latinas may be less likely to suggest condom use than their White or African American counterparts. This is possibly due to culturally constructed gender role constraints, female modesty, male dominance in sexual behavior, and/or misconceptions about the use and efficacy of condoms (Marin, Tschann, Gomez, & Kegeles, 1993; Sikkema et al., 2000). Latinos are reported to have negative attitudes about condoms and are less likely than other ethnic groups to believe that condoms protect against HIV (Marin et al., 1993). Homosexuality among Latinos has historically been viewed as negative and shameful. In some cases, Latino men who are the inserting partner in homosexual anal intercourse may not identify this as a homosexual activity and may not self-identify as homosexual (Kaiser Permanente National Diversity Council and the Kaiser Permanente National Diversity Department, 2001). Moreover, Latino men who have sex with both women and men may identify themselves as heterosexual, thus denying risky behaviors that may lead to the contraction of HIV (Bibgy, 2002).

Health Disparities

Widening disparities can also be evidenced by the disproportionate prevalence of tuberculosis (TB), hepatitis C, syphilis, and other sexually transmitted infections (STIs) among Latinos compared with Whites. While the number of TB cases among Whites actually decreased 42% during 1985-1997, the number of reported TB cases increased 36% for Latinos during that time (Carter-Pokras & Woo, 1999; U.S. Department of Health and Human Services, 1985). Individuals born outside the U.S. accounted for 53.3% of the U.S. TB caseload, and Mexico (25.6%) was the country of origin of the highest number of immigrants who developed TB. Resistance to isoniazid and rifampin among foreign-born individuals was 1.2% compared with 0.6% for those born in the U.S. (CDC, 2004). Hepatitis C is more common in Latinos than in African Americans and Whites (CDC, 1998). Furthermore, syphilis rates continue to rise, particularly among MSMs and those with HIV. The number of syphilis cases among Latino men increased by 50% from 2000 to 2001 (CDC, 2001c). The presence of some STIs due to inflammation or ulceration of mucous membranes and skin allowing HIV easier access compounds an individual's susceptibility to HIV infection.

Treatment Disparities

Medical providers are less likely to prescribe medications for Latinos in treating asthma, cardiovascular disease, HIV/AIDS, mental illness, and pain. These disparities in pharmaceutical treatment are substantial and often persist even after adjustment for differences in income, age, insurance coverage, and co-existing medical conditions. Minority patients with HIV/AIDS are less likely to receive antiretroviral therapy (Moore, Stanton, Gopalan, & Chaisson, 1994). Latinos with HIV are more likely to be publicly insured, uninsured, or have less private insurance than Whites: 50% vs. 32%, 24% vs. 17%, and 23% vs. 44% respectively (Fleishman, 2002). According to a 1999 study, Latinos were more likely than Whites to report postponing medical care due to a lack of transportation or being too sick to go to the doctor (Cunningham et al., 1999). Latinos are also more likely than Whites to delay care after an HIV diagnosis (Turner et al., 2000) and are less likely to use medications when they are prescribed.

Among Medicaid recipients, HIV medication use was lower for minority beneficiaries despite comparable coverage for pharmacy and other health services. Moreover, initiation of treatment was delayed for injection drug users. Among treated individuals, the use of protease inhibitors (PIs) combined with the use of non-nucleoside reverse transcriptase inhibitors (NNRTIs) use was lower for African Americans and Latinos, indicating that these populations may be lacking in an optimal regimen that typically would combine two nucleoside reverse transcriptase inhibitors (NRTIs) with one PI or one NRTI with one NNRTI and one PI. In other words, these populations were less likely to receive the benefits of combination therapy. Being African American or Latino was associated with an 8% reduction in the proportion of time on PI and NNRTI therapy following initiation of treatment (Crystal, Sambamoorthi, Moynihan, & McSpirtt, 2001). Attitudes toward PIs and medication adherence in an inner city population of HIV-infected African Americans and Latinos demonstrated suboptimal adherence with more than 50% of respondents failing to take their PI medications as prescribed within the previous month. Unsurprisingly, individuals who had recently used illegal drugs were more likely than their counterparts to be non-adherent to PI therapy. Nonadherent patients were more likely to be concerned about the potential side effects of PIs and were more likely to believe that it was okay to skip doses (Demmer, 2003). More research needs to be conducted to investigate the reasons behind nonadherence to PI medications among Latinos and to identify the role health care providers play in their patients' non-adherence.

Adolescents, women, African Americans, and Latinos—the growing patient population with HIV—are generally getting delayed treatment and fewer medications than recommended by Federal guidelines.

Utilization of health care resources by HIV-positive Latino individuals has shown a lower access to highly active antiretroviral therapy (HAART), as well as lower outpatient mental health services, fewer home health visits, and a higher use of emergency inpatient services (Menke, Giordano, & Rabeneck, 2003). Race and ethnicity have been shown to negatively impact participation in research trials and access to experimental treatment among patients with HIV. As previously mentioned in the Ethics chapter, African Americans and Latinos are less likely to participate in trials than Whites and are also less likely to receive experimental medications (Gifford et al., 2002). Studies have shown that less experienced physicians tend to delay the initiation of treatment and use fewer medications than Federal guidelines advise. Growing patient population with HIV (adolescents, women, African Americans, and Latinos) are generally treated by these physicians. These groups are more likely to be HIV symptomatic at the time of diagnosis and at the beginning of treatment when compared with their other HIV-infected counterparts (Baker, 1998).

HIV Subtypes

HIV-1 is the major cause of AIDS worldwide, with Group M being responsible for most of the infections. Subtype B predominates in the United States, Central and South America, the Caribbean, Europe, and Eastern Europe, while HIV-2 is endemic in West Africa. Latinos are mainly affected by HIV-1, but it is important to be aware that global travel and migration patterns may introduce subtypes not typical for a particular region. If atypical presentations of HIV are suspected, an epidemiologic link to Africa is evidenced, or HIV is suspected but an HIV screening test is negative, the provider should consider the possibility of infection with a different HIV group and/or subtype (Sullivan et al., 2000).

Simultaneous Infection of Tuberculosis (TB) and HIV

The number of people infected with HIV is gradually increasing, and the numbers of HIV/TB co-infections are also increasing. In patients dually infected with TB and HIV, clinicians are challenged with a number of unique issues related to TB diagnosis, pathogenesis, and treatment. Advanced HIV infection is associated with the greatest relative risk of TB reactivation, being nearly 10 times that of persons without HIV (Horsburgh, 2004). Therefore, treatment is warranted for all HIV-infected persons with a positive tuberculin skin test

with >5mm of induration. Providers must be aware that false-negative tuberculin reactions are often observed, particularly with advanced HIV disease, and a negative test does not rule out TB. The incidence of severe cases (miliary TB, tuberculous meningitis, and extrapulmonary TB) is high among AIDS-associated TB cases.

Among HIV-infected adults, TB cases are generally regarded as endogenous exacerbation; however, they may include primary infection and reinfection. The combined use of a PI with rifampin is contraindicated for the treatment because rifampin induces hepatic cytochrome P-450 and increases the metabolism of PIs and NNRTIs to markedly decrease the blood concentrations. Accordingly, the treatment for TB should take priority over that for HIV/AIDS related conditions in the HIV-positive patient with tuberculosis. When HAART is necessary for HIV/AIDS treatment during the course of TB, rifampin should be substituted with rifabutin because the effect of rifabutin to induce cytochrome P-450 is less potent than that of rifampin. The dose of rifabutin is also reduced by 50% in this setting. The use of Bacille Calmette Guerin (BCG) vaccination is contraindicated for HIV-infected patients, because it is a live bacterium vaccine, and disseminated BCG (*M. bovis*) infection may occur following vaccination in immunocompromised patients (Nagai, 2003). Providers should be aware that many Latin American and Caribbean countries use the BCG vaccine, which may result in a positive TB screen. Nonetheless, a person who has a positive skin test, and who was previously given BCG vaccine, is treated the same as a person who has not received BCG; they are treated as if they have TB. Overall clinical guidelines require a chest x-ray and complete clinical assessment to determine if TB is active and to determine which antibiotic regimens are appropriate. As noted above, this may necessitate altering or terminating HIV medications due to interaction with certain TB medications.

HIV RNA Levels and CD4 Counts

Both race and gender influence the values of HIV-1 RNA (viral load) and the rate of HIV-1 disease progression as indicated by a decline in CD4 lymphocyte counts over time. For example, women had more rapid declines in CD4 lymphocyte counts over time than men, and non-White individuals had slower declines in CD4 lymphocyte counts than Whites (Anastos et al., 2000). A number of studies have shown that HIV positive women have a lower viral load than men when matched by CD4+ counts (Napravnik et al., 2002). The relevance of these differences on disease progression in women and guidelines for initiating therapy are being actively investigated (Moore et al., 2003).

CD4 lymphocyte counts were lower for Latino and African-American patients when compared with their White counterparts. Initial HIV-1-RNA levels following diagnosis were higher in Latino patients than in non-Latino patients, and Latino patients were also more likely to present with major opportunistic infections (OIs) (Swindells et al., 2002). Variations in disease manifestation could provide clues regarding the factors that influence HIV disease progression and may indicate that guidelines for therapy should be adjusted for demographic characteristics.

Genetic Variations

While it is clear that culture and environment impact on an individual's health attitudes and disease outcomes, biological differences between populations also play an important role. We are gaining an increasingly greater appreciation of genetic differences across racial and ethnic groups that contribute to differences in disease risk, disease pathogenesis and outcomes, and even the response to drug treatment. An expanding body of research seeks to elucidate genetic factors that modulate susceptibility to HIV infection, transmission, disease progression, and treatment outcomes.

A well-studied example of the impact of genetics involves the process of HIV infection of lymphocytes. In the HIV infection cycle, the virus requires association with both the lymphocyte surface receptors CD4 and the beta-chemokine receptor CCR5 for viral attachment and fusion. A 32-base pair (bp) deletion mutation in the beta-chemokine receptor CCR5 gene alters the structure of the chemokine receptor and diminishes HIV attachment. This genetic variant has been associated with markedly diminished disease progression in HIV-1 positive individuals (Downer et al., 2002; Kostrikis et al., 1999; Lu et al., 1999). Studies indicate that individuals who are homozygous for this deletion mutation (D32/D32) are protected against HIV-1 infection despite multiple high-risk exposures. Research also suggests that CCR5/D32 heterozygotes have a slower progression from HIV to AIDS. Data show high frequency of CCR5/D32 heterozygosity among Whites and intermediate and low-level D32 allele frequencies among Puerto Ricans and Hawaiians (Lu et al., 1999). Studies have focused on the geographic distribution of the Delta CCR5 allele across diverse racial and ethnic populations, particularly in considering epidemiological aspects of HIV disease.

The Delta CCR5 allele is not present in indigenous Mexican populations, but is found in approximately 8% of the population in Spain. The findings of this study demonstrate consistency when con-

sidering Mexico's colonial past and the genetic admixture from Europe that was initiated during the Spanish conquest (Salas-Alanis, Mellerio, Ashton, & McGrath, 1999).

As another example, human leukocyte antigens (HLA) have been studied for their association with HIV transmission risk, pathogenesis, and immunologic control. Illustrating this point, Winchester et al. (1995) studied major histocompatibility complex (MHC) class II DR alleles and their association with risk of maternal-fetal HIV transmission. They observed that the alleles DRB1*1301, 1302, and 1303 were associated with Latino and African-American infants seroreverting or becoming HIV-infected. In contrast, only the DR2 allele DRB1*1501 was associated with seroreversion in Caucasian infants.

HIV infection is thought to involve oxidative stress and depletion of glutathione. Providers should be aware that there are suspected ethnic differences in a gene responsible for glutathione synthesis (Willis et al., 2003). Such findings may have implications in the nutritional management of HIV in these populations (e.g., the use of trace mineral supplementation with selenium).

Opportunistic Infections

Physicians should have an increased index of suspicion for opportunistic diseases (e.g. *Cryptosporidium*, *Giardia*, and *Isospora*) in AIDS patients with diarrhea who have newly immigrated from, or recently traveled to Latin America. For HIV-positive patients who travel to Latin America, food and water precautions should be advised and trimethoprim-sulfamethoxazole (TMP-SMX) prophylaxis should be considered for the prevention of *Isospora* infection (Sorvillo et al., 1995). TMP-SMX should also be given to adults and adolescents with CD4 lymphocyte counts below 200 for prophylaxis against *Pneumocystis jiroveci*, pneumonia. In patients allergic to sulfa drugs, dapsona or atovaquone may be substituted. Guidelines for younger children differ from those for adults. An analysis of the risk of OI in the HAART era among HIV positive U.S.-born Latinos compared to Latinos born in Mexico and Central America suggests that variation in OI risk among Latinos may be at least partially explained by acculturation and immigration factors, such as loss of social support systems and negative lifestyle changes (Wohl et al., 2003).

Conclusion

The provider must remain mindful of the many factors that contribute to risk of infection among Latinos and the impact that cultural and gender expectations may have on the Latino patient. There is substantial variance in the way that Latino cultural beliefs and values can impact upon health practices. Clinical providers should be aware of biological variations in the manifestation of HIV disease in the Latino patient in order to ensure best care practices. The culturally competent provider will refrain from stereotyping and utilize his or her experiences in combination with culturally and linguistically relevant materials to more effectively frame patient interactions and communication strategies.

The HIV/AIDS epidemic in the Latino community presents important challenges to community leaders, patients, health care professionals, policymakers, scientists, researchers, and public health officials. A holistic approach to address the impact of HIV/AIDS in the Latino community is extremely important in order to reduce the incidence of HIV/AIDS and related treatment disparities among Latinos and consequently improve health care and health status for all.

References

- Abraido-Lanza, A.F., Dohrenwend, B.P., Ng-Mak, D.S., & Turner, J.B. (1999). The Latino mortality paradox: A test of the 'salmon bias' and healthy migrant hypothesis. *American Journal of Public Health, 89*, 1543-8.
- Anastos, K., Gange, S.J., Lau, B., Weiser, B., Detels, R., Giorgi, J.V., et al. (2000). Association of race and gender with HIV-1 RNA levels and immunologic progression. *Journal of Acquired Immune Deficiency Syndrome, 24*(3), 218-26.
- Baker, R. (1998). 25% of HIV positive individuals not treated according to Federal guidelines. *Bulletin of Experimental Treatments for AIDS (BETA)*. San Francisco AIDS Foundation, p. 8.
- Bigby, J. (2002). *Cross-cultural medicine*. Philadelphia: American College of Physicians.
- Carter-Pokras, O., & Woo, V. (1999). Health profile of racial and ethnic minorities in the United States. *Ethnicity and Health, 4*(3), 117-20.
- Centers for Disease Control and Prevention. (1998). Recommendations for prevention and control of hepatitis C virus (HCV) infection and HCV-related chronic disease. *MMWR, 47*, 1-39.
- Centers for Disease Control and Prevention. (2000). HIV/AIDS surveillance by race/ethnicity, L238 Slide Series, through 2000.

- Centers for Disease Control and Prevention. (2001a). HIV/AIDS surveillance by race/ethnicity, L238 Slide Series, through 2001.
- Centers for Disease Control and Prevention. (2001b). *HIV/AIDS surveillance report, year end edition, 13(2)*, 1-44.
- Centers for Disease Control and Prevention. (2001c). Primary and secondary syphilis U.S. 2000-2001. *MMWR, 51(43)*, 971-3.
- Centers for Disease Control and Prevention. (2003a). Characteristics of persons living with AIDS and HIV, 2001. *HIV/AIDS surveillance supplemental report, 9(2)*, 1-27.
- Centers for Disease Control and Prevention. (2003b). Late versus early testing of HIV-16 Sites, United States, 2000-2003. *MMWR, 52(25)*, 581-6.
- Centers for Disease Control and Prevention. (2004). Trends in tuberculosis = ≠United States, 1998-2003. *MMWR, 53(10)*, 209-14.
- Crystal, S., Sambamoorthi, U., Moynihan, P.J., & McSpirt, E. (2001). Initiation and continuation of newer antiretroviral treatments among Medicaid recipients with AIDS. *Journal of General Internal Medicine, 12*, 850-9.
- Cunningham, W.E., Andersen, R.M., Katz, M.H., Stein, M.D., Turner, B.J., Crystal, S., et al. (1999). The impact of competing subsistence needs and barriers on access to medical care for persons with human immunodeficiency virus receiving care in the United States. *Medical Care, 37(12)*, 1270-81.
- Demmer, C. (2003). Attitudes toward HIV protease inhibitors and medication adherence in an inner city HIV population. *AIDS Patient Care and STDS, 17(11)*, 575-80.
- Downer, M.V., Hodge, T., Smith, D.K., Qari, S.H., Schuman, P., Mayer, K.H., et al. (2002). Regional variation in CCR5-Delta32 gene distribution among women from the US: HIV Epidemiology Research Study (HERS). *Genes and Immunity, 3(5)*, 295-8.
- Fleishman, J. (2002). Personal communication: Analysis from the HIV Cost and Services Utilization Study (HCSUS) data.
- Flores, G. (2000). Culture and the patient-physician relationship: Achieving cultural competency in health care. *Journal of Pediatrics, 136*, 14-23.
- Gifford, A.L., Cunningham, W.E., Heslin, K.C., Andersen, R.M., Nakazono, T., Lieu D.K., et al. HIV Cost and Services Utilization Study Consortium. (2002). Participation in research and access to experimental treatments by HIV-infected patients. *New England Journal of Medicine, 346(18)*, 1373-82.
- Gil, R.M., & Inoa-Vazquez, C. (1996). *The Maria paradox: How Latinas can merge old world traditions with new world self-esteem*. New York: G.P. Putnam.
- Horsburgh, C. R. (2004). Priorities for the treatment of latent tuberculosis infection in the United States. *New England Journal of Medicine, 350(20)*, 2060-7.

- Kaiser Permanente National Diversity Council and the Kaiser Permanente National Diversity Department. (2001). *A provider's handbook on culturally competent care: Latino population* (2nd ed.). Oakland, CA: Kaiser Permanente.
- Klevens, R.M., Diaz, T., Fleming, P.L., Mays, M.A., & Frey, R. (1999). Trend in AIDS among Hispanics in the United States, 1991-1996. *American Journal of Public Health, 89*, 1104-6.
- Kostrikis, L.G., Neumann, A.U., Thomson, B., Korber, B.T., McHardy, P., Karanicolas, R., et al. (1999). A polymorphism in the regulatory region of the CC-chemokine receptor 5 gene influences perinatal transmission of human immunodeficiency virus type 1 to African-American infants. *Journal of Virology, 73*(12), 10264-71.
- Landrine, H., & Klonoff, E.A. (1994). Cultural diversity in causal attributions for illness: The role of the supernatural. *Journal of Behavioral Medicine, 17*, 181-93.
- Lu, Y., Nerurkar, V.R., Dashwood, W.M., Woodward, C.L., Ablan, S., Shikuma, C.M., et al. (1999). Genotype and allele frequency of a 32-base pair deletion mutation in the CCR5 gene in various ethnic groups: Absence of mutation among Asians and Pacific Islanders. *International Journal of Infectious Diseases, 3*(4), 186-91.
- Marin, B. (1996, July). Traditional gender roles: Beliefs increase coercion and lower condom use in Latino men. Poster session presented at the 11th International Conference on AIDS, Vancouver, B.C., Canada.
- Marin, B.V., Tschann, J.M., Gomez, C.A., & Kegeles, S.M. (1993). Acculturation and gender differences in sexual attitude and behaviors: Hispanic vs. non-Hispanic white adults. *American Journal of Public Health, 83*, 1759-61.
- Menke, T.J., Giordano, T.P., & Rabeneck, L. (2003). Utilization of health care resources by HIV-infected white, African-American, and Hispanic men in the era before highly active antiretroviral therapy. *Journal of the National Medical Association, 95*(9), 853-61.
- Mikhail, B.I. (1994). Latino mothers' beliefs and practices regarding selected children's health problems. *Western Journal of Nursing Research, 16*, 623-38.
- Moore, A.L., Johnson, A.M., Katlama, C., Blaxhult, A., Dietrich, M., Colebunders, R., et al. (2003). Virologic, immunologic and clinical response to highly active antiretroviral therapy: The gender issue revisited. *Journal of Acquired Immune Deficiency Syndrome, 32*, 452-461.
- Moore, R.D., Stanton, D., Gopalan, R., & Chaisson, R.E. (1994). Racial differences in the use of drug therapy for HIV disease in an urban community. *New England Journal of Medicine, 330*, 763-8.
- Morgan, C., Park, E., & Cortes, D.E. (1995). Beliefs, knowledge, and behavior about cancer among urban Hispanic women. *Journal of the National Cancer Institute Monographs, 18*, 57-63.

- Murguia, A., Peterson, R.A., & Zea, M.C. (2003). Use and implications of ethnomedical health care approaches among Central American immigrants. *Health and Social Work, 28*(1), 43-51.
- Nagai, H. (2003). HIV infection and tuberculosis. *Kekkaku, 78*(1), 45-49.
- Naprvanik, S., Poole C., Thomas, J.C., & Eron, Jr., J.J. (2002). Gender difference in HIV RNA levels: a meta-analysis of published studies. *Journal of the Acquired Immune Deficiency Syndrome, 31*, 11-19.
- National Alliance of State and Territorial AIDS Directors. (2003). *Addressing HIV/AIDS: Latino perspectives & policy recommendations*. Ayala, G., & Nuno, M. Washington, DC: NASTAD.
- Neal, J., & Fleming, P. (2002). Frequency and Predictors of Late HIV diagnosis at the United States, 1994-1999. 9th Conference on Retroviruses and Opportunistic Infections: Abstract #474M.
- Oman, D., & Red, D. (1996). Religion and mortality among the community-dwelling elderly. *American Journal of Public Health, 86*, 111-2.
- Ramirez, R.L. (1993). *Dime capitan: Reflexiones sobre la masculinidad*. Rio Piedras, Puerto Rico: Ediciones Huracan.
- Salas-Alanis, J.C., Mellerio, J.E., Ashton, G.H., & McGrath, J.A. (1999). Frequency of the CCR5 gene 32-basepair deletion in Hispanic Mexicans. *Clinical & Experimental Dermatology, 24*(2), 127-9.
- Sikkema, K.J., Kelly, J.A., Winett, R.A., Solomon, L.J., Cargill, V.A., Roffman, R.A., et al. (2000). Outcomes of a randomized community-level HIV prevention intervention for women living in 18 low-income housing developments. *American Journal of Public Health, 90*, 57-63.
- Sorvillo, F.J., Lieb, L.E., Seidel, J., Kerndt, P., Turner, J., & Ash, L.R. (1995). Epidemiology of isosporiasis among persons with acquired immunodeficiency syndrome in Los Angeles County. *American Journal of Tropical Medicine and Hygiene, 53*(6), 656-9.
- Stycos, J.M. (1952). Family and fertility in Puerto Rico. In F. Cordasco & E. Buchioni (Eds.), *The Puerto Rican community and its children on the mainland: A source book for teachers, social workers, and other professionals*. Metuchen, NJ: Scarecrow Press.
- Sullivan, P.S., Do, A.N., Ellenberger, D., Pau, C.P., Robbins, K., Kalish, M., et al. (2000). Human immunodeficiency virus (HIV) subtype surveillance of African-born persons at risk for group O and group N HIV infections in the United States. *Journal of Infectious Diseases, 181*, 463-9.
- Swindells, S., Cobos, D.G., Lee, N., Lien, E.A., Fitzgerald, A.P., Pauls, J.S., et al. (2002). Racial/ethnic differences in CD4 T cell count and viral load at presentation for medical care and in follow-up after HIV-1 infection. *AIDS, 16*(13), 1832-4.

- Turner, B.J., Cunningham, W.E., Duan, N., Andersen, R.M., Shapiro, M.F., Bozzette, S.A., et al. (2000). Delayed medical care after diagnosis in a U.S. national probability sample of persons infected with the human immunodeficiency virus. *Archives of Internal Medicine*, 160, 2614-22.
- U.S. Department of Health and Human Services. (1985). *Secretary's task force report on Black and minority health*.
- Wendroff, A.P. (1990). Domestic mercury pollution. *Nature*, 6294, 347-623.
- Willis, A.S., Freeman, M.L., Summar, S.R., Barr, F.E., Williams, S.M., Dawson, E., et al. (2003). Ethnic diversity in a critical gene responsible for glutathione synthesis. *Free Radical Biology & Medicine*, 34(1), 72-6.
- Winchester, R., Chen, Y., Rose, S., Selby, J., & Borkowsky, W. (1995). Major histocompatibility complex class II DR alleles DRB1*150 and those encoding HLADR13 are preferentially associated with a diminution in maternally transmitted human immunodeficiency virus 1 infection in different ethnic groups: Determination by an automated sequence-based typing method. *Proceedings of the National Academy of Science*, 92(26), 12374-8.
- Wohl, A.R., Lu, S., Turner, J., Kovacs, A., Witt, M., Squires, K., et al. (2003). Risk of opportunistic infection in the HAART era among HIV-infected Latinos born in the United States compared to Latinos born in Mexico and Central America. *AIDS Patient Care and STDS*, 17(6), 267-75.

Encounters

In developing a positive culturally competent encounter, Lecca, Quervalu, Nunes, Gonzales (1998) explain, “By taking account of the cultural beliefs of the individuals and incorporating them into [a consultation], the [provider] is making the treatment more familiar to the patient and enhancing its chances of success.” Provider sensitivity to the extra effort the Latino patient has made to seek care despite language and cultural barriers can help create a welcome atmosphere for the encounter. The information presented in this chapter attempts to address important issues regarding provider encounters with HIV-infected Latino patients. Some of the main factors that will direct the consult include the patient’s generational status, the patient’s country of origin, the number of years an immigrant patient has resided in the United States, and the patient’s ethnic/cultural beliefs.

The Latino Patient Encounter

Chong (2002) provides an excellent format for clinical encounters with Latino patients, discussing the use of both verbal and nonverbal communication. She has developed a five-item tool with the acronym GREET to help providers characterize the Latino patient to ensure more effective encounters. Chong offers culturally relevant suggestions for initiating the provider’s first question, as well as instruction for assessment of a patient’s clinical history to include personal data, history of current health problems, past medical history/family history, cultural practices, and questions regarding sexual history.

Verbal and Nonverbal Communication During a Latino Patient Encounter

Eye Contact

Making eye contact with Latino patients is important during the clinical encounter to demonstrate respect for the patient, concern regarding what the patient has to say, and to convey a sense of caring. Providers must find a balance of the right amount and appropriate timing of eye contact. It is possible to exceed proper amounts, particularly with patients of the opposite sex. Eye contact is even more crucial when attempting to communicate with the patient through the use of an interpreter.

Facial Expression

A provider's facial expression has the power to express respect and warmth. A provider can attempt to find common ground through a facial expression, such as one that might acknowledge the long wait time in the clinic or another factor in the immediate environment. "An unexaggerated, friendly smile combined with brief eye contact can make a Latino patient feel welcome in [a provider's] office," and more relaxed during a medical visit for HIV/AIDS (Chong, 2002, p. 97).

Gestures

Many people like to express themselves by using their arms and hands, and Latinos are no exception. "Gestures are as important as words for Latinos when they communicate," (Chong, 2002, p. 97). It is important for a provider to stand up, walk over to, and greet the patient when he or she first enters the provider's office. The provider can also gesture for the patient to sit down to make the patient feel more welcome. When having encounters with HIV-infected patients, it is critical that the provider makes the Latino patient feel welcome and accepted.

Touch

Physical expression during greeting or difficult moments is common among Latinos, as well as many others. Although mainstream Anglo culture within the United States often establishes the importance of privacy and personal space, these are not often equally valued among Latinos. Providers of HIV/AIDS related care need to determine a balance between their ability to comfortably transmit a caring attitude, and the Latino patient's needs for familiar modes of contact and physical expression. Providers should also remember that touching a person who is receiving difficult medical news relating to HIV is often reassuring, as the patient may feel isolated, diseased, and not fully able to comprehend the effects of HIV, particularly when a lack of accurate knowledge exists.

Voice Intonation

When addressing Latinos with limited English proficiency, it is important for the provider to speak in a "warm, friendly and moderate tone of voice," (Chong, 2002, p. 98). Speaking loudly is not likely to increase the patient's ability to comprehend English, and is more likely to offend the patient and make him or her uncomfortable.

Addressing Latino Patients (The Use of Titles)

In the Latino culture, a title signifies respect. It is proper to use last names when addressing new patients, as calling a Latino by his or her first name signifies a strong familiarity or close personal tie. A male Latino can be addressed as “Mr.” followed by their last name. Similarly, a Latina can be addressed as “Miss” or “Mrs.” depending on her age and/or marital status. If the patient population is predominately Latino, a provider may use the titles *Señor* (Mr.), *Señora* (Mrs.), and *Señorita* (Miss) preceding either the patient’s first or last name. It is also appropriate for a Spanish-speaking provider to refer to an adult Latino patient (particularly an elder patient) as *Usted*, which is the formal version of the word “you” in Spanish, and to continue using *Usted* until the patient indicates a preference for *tu*, which is the informal version of the word “you” in Spanish.

In the Latino culture, a title signifies respect.

Communication and the Use of Interpreters

As previously discussed, if a practitioner cannot speak the patient’s native language fluently, an interpreter should be requested. Until arranging a formal translated session, providers should avoid medical jargon and use simple terms in English. In addition, providers must be wary of raising their voices in an effort to assist the patient’s comprehension. Not only might this be annoying and/or appear disrespectful, but the patient also might misinterpret the tone of voice as castigating in nature. It may be helpful for the provider to be aware of key terms related to HIV/AIDS in Spanish, some of which can be found in the glossary; however, a provider should always depend on a trained interpreter if he or she is not proficient in the Spanish language.

When an interpreter is used, it is ideal for the patient, interpreter, and health care provider to sit facing each other in a way that forms a triangle between the three individuals. The health care provider should address and make eye contact with the patient the entire time and this should be reciprocated by the patient. Interpreters are often used incorrectly, and it is not uncommon to see patients and providers solely addressing the interpreter and disregarding each other. It is important that the provider remain focused on the patient throughout the encounter to help build *confianza* (trust).

The interpreter is there only to ensure that the patient understands what the provider is saying, and the primary relationship that must be developed is that between the patient and the provider.

Latino patients may attempt to bring their children, other family members, or even friends to interpret a medical visit. While it may reduce the patient's stress, it is not appropriate to use family members or friends as interpreters, particularly when sensitive issues, such as HIV-related risk behaviors, need to be discussed. It is also inappropriate to use untrained bilingual staff or bilingual patients in waiting rooms as interpreters. Trained interpreters should be the only option for providers who are not fluent in the patient's language. Providers should also attempt to use bilingual written materials when appropriate to better inform patients, while remaining aware that some Latino patients may be unable to read in either English or Spanish. Many health-related documents are written at an educational level far beyond the comfort zone of many underserved Latinos. Therefore, it is strongly recommended that all educational materials be developed at no higher than a fourth grade reading level. This will help alleviate literacy issues for those who may find more advanced materials inaccessible. The use of culturally relevant pictures, diagrams, or artwork may also facilitate comprehension of a health-related matter.

The Cross-Cultural Health Care Program (2004) cites several guidelines for interpreters. According to this guide, interpreters are responsible for conveying all of the necessary content between the patient and provider while taking cultural context into account. Interpreters should not translate everything word for word, but should rather focus on the content of the message and attempt to convey this message to the patient/provider as accurately as possible. Cultural variations in wording and expressions can be confusing, and trained interpreters must be aware of these nuances in order to ensure proper content translation. Interpreters are also responsible for interpreting the content in its entirety, and should not omit any of the spoken information, no matter how incorrect or offensive they may find the message to be. In cases where the interpreter foresees a comment as being impolite or disrespectful to the patient, the interpreter may advise the provider of the implications of the statement before translation. The interpreter also must not add, change, or condense any of the content being conveyed from the provider to the patient or vice versa. Interpreters must agree to keep all information from an encounter confidential and interpret with a nonjudgmental attitude. The interpreter should maintain an impartial attitude and ensure that personal opinions are not inflicted on the patient or the provider. It is the provider's ethical responsibility to guarantee that interpreters follow these guidelines and maintain patient confidentiality at all times. If the provider suspects unethical interpreting, a report must be made and filed with the proper authorities.

Characterizing the Latino Patient and Developing *Confianza*: The GREET Model

The GREET model (Chong, 2002) presents the opportunity for providers to collect necessary cultural and background information while simultaneously allowing for the demonstration of interest in the lives of their Latino patients, thus enabling the establishment of *confianza* (trust). The GREET acronym stands for Generation, Reasons for Immigrating to the United States, Extended or Nuclear Family, Ethnic Behavior, and Time Living in the United States.

G= Generation

Before taking a medical history, it is important to determine if the patient is an immigrant, a second, third, or fourth generation Latino, or a Latino with an ancestry solely derived from territories that formerly belonged to Mexico. The purpose of this determination is that immigrant Latinos who have not lived in the United States for an extended period of time will be more likely to maintain their traditional cultural beliefs. Recent immigrants may face additional hardships in day-to-day life and may be more likely to experience a lack of job opportunities and less access to health care. Second generation Latinos may show some degree of acculturation but may also be torn between the strong cultural influences of their parents' native culture and the mainstream U.S. culture to which they have had more exposure. Sometimes it is assumed that third, fourth, and fifth generation Latinos are more acculturated than their first or second generation counterparts. While this may be true the majority of the time, health care providers must be careful not to make assumptions about Latino patients solely based on their generational status. In some instances, a fourth generation Latino may be no more acculturated than a recent immigrant and may not be proficient in the English language.

R= Reasons for Immigrating to the United States

When questioning a recent immigrant, the provider must not discuss legality issues regarding immigration status because this may break a trust bond that may have been previously established between the provider and the patient and will certainly impede the establishment of *confianza*. Also, providers need to be aware that Latinos recently arriving to the U.S. may be seeking HIV services because of stigmatization that occurs in their country of origin and may finally be ready to address their needs to a provider. It may be helpful to ask about the patient's origin and reasons for immigrating, while remaining sensitive

to the fact that immigrants may feel threatened due to a potential lack of documentation. Showing interest in learning more about the family's country of origin and the patient's reasons for immigrating will help the provider better understand the patient and his or her culture, while building trust and strengthening the relationship between the patient and the provider.

E= Extended or Nuclear Family

Knowing whether the Latino patient lives in close proximity to either the extended or nuclear family provides valuable information into a Latino's main source of social support. The extended family is a very important source of emotional support for the Latino patient and is often lost when individuals immigrate to the United States. Latino families often live communally and share childcare responsibilities. Many third and fourth generation Latinos maintain close ties to their families and countries of origin and remain in the United States mainly because of employment opportunities (Chong, 2002). HIV-positive Latinos with an extended network of loving and accepting family members may be better prepared to cope with the challenges of life with HIV/AIDS. Family members may encourage HIV-infected Latinos to seek care and help them maintain their treatment regimens. While the extended family can serve as a support system for an HIV-infected Latino, they can also serve as a source of stress if they respond negatively to the patient's diagnosis. Conservative family members (particularly elders) may stigmatize or reject the HIV-infected patient because of the association between HIV and sexual promiscuity, drug use, and homosexuality. Disapproval from family members may be extremely difficult for the patient and may result in a failure to disclose his or her seropositive status for fear of rejection and/or stigmatization. Providers should be sensitive to the feelings and opinions of the Latino patient's family members as perceived by the Latino patient.

E= Ethnic Behavior

A provider can also acquire useful information in forming a bond with the patient by understanding his or her preferences regarding food, music, and recreational activities. In addition, learning about the holidays of a given culture may provide insight regarding a patient's culture (Chong, 2002). It is important for the provider to inquire about cultural dietary habits as this may help guide the provider's understanding of the clinical manifestations of non-HIV-related health problems like diabetes or hypercholesterolemia.

Certain treatments and medications for HIV and AIDS, such as protease inhibitors (PIs), have resulted in hyperglycemia and an exacerbation of diabetes in patients with a predisposition for these illnesses. Providers for HIV/AIDS patients should be aware of these complications when prescribing treatment plans to their Latino patients.

T= Time Living in the United States

A common inference is that the longer a Latino patient has lived in the United States, the higher his or her degree of acculturation. While this does not hold true for all Latinos, it can be expected that long periods of exposure to a host country's culture can cause immigrants to adopt at least some aspects of the host culture. In keeping with this point, data indicate that 66% of Latinos are U.S.-born, and a large number are longtime residents of the United States (U.S. Census Bureau, 1993). Another phenomenon that health care providers need to be aware of is the "Latino Paradox." This paradox refers to the negative relationship between a Latino immigrant's health behavior and his or her acculturation status; as Latino immigrants become more acculturated, their general health behaviors worsen (e.g., they may become more likely to participate in HIV risk behaviors such as increasing number of sex partners and/or needle sharing). Interestingly enough, this relationship is unrelated to the socioeconomic status of the Latino immigrant (Falcón, Aguirre-Molina, & Molina, 2001).

Using the GREET Approach Vignette

Background: Veronica Rodriguez is a 29-year-old woman who has been referred by a local community group to Dr. Johnson for HIV testing after discovering that her husband of 6 years has been involved in sexual activity outside their relationship.

Dr. Johnson: Good morning *Señora* (Mrs.) Rodriguez. Please come in. (makes eye contact, wears a warm smile, and offers a friendly handshake)

Dr. Johnson: What brings you in today? Are you feeling all right?

Veronica: I want to get a check-up.

Dr. Johnson: When was the last time you had one?

Veronica: I went to see my parent's doctor in Mexico a couple of years ago. I was there to celebrate *el Día de los Muertos* with my family, but I became very sick the night before and my parents took me to the doctor.

Dr. Johnson: Do your parents still live in Mexico?

Veronica: Yes, they have lived there all of their lives.

Dr. Johnson: What part of Mexico do they live in?

Veronica: They live in a small town close to the border. I try to visit them whenever I can.

Dr. Johnson: Were you raised in Mexico as well?

Veronica: Yes for the most part, I moved here with my aunt when I was 12.

Dr. Johnson: What caused you to move?

Veronica: My parents wanted me to move because they said there were better jobs and better opportunities in the United States.

Dr. Johnson: Do you live close to any family members besides your aunt?

Veronica: No, not really. My aunt lives pretty close but she is always at work and most of my other family members still live in Mexico. I live with my husband and our three children.

Dr. Johnson: Do you have any current health problems that are concerning you today?

Veronica: Actually I just found out that my husband has been seeing people outside of our marriage and I wanted to get tested for HIV.

Dr. Johnson: Do you and your husband use any methods of birth control?

Veronica: Well, I had my tubes tied after our third child so we don't have to worry about that. At one point I wanted to ask him to start wearing condoms because I thought maybe he was seeing other people but I did not want to get in an argument with him about it so I didn't bring it up.

Dr. Johnson: Well I am glad that you came to see me today Mrs. Rodriguez, we can definitely help you.

Discussion of the GREET Approach

Dr. Johnson created a friendly environment for Veronica Rodriguez to share her background and her current health concerns. Dr. Johnson listened attentively and prompted her patient with follow-up questions about her family and her living situation. This brief conversation helped to establish *confianza* between the patient and provider and also supplied Dr. Johnson with some important information about Mrs. Rodriguez's background and culture.

Generation: Mrs. Rodriguez is a first-generation Latina. It is possible that Mrs. Rodriguez holds more traditional cultural values and may believe in *curanderismo* or other non-standard treatment methods. Despite being first generation Latina, Mrs. Rodriguez is extremely proficient in English and does not need the services of an interpreter.

Reasons: Mrs. Rodriguez emigrated from Mexico to the United States because her parents thought she would find more opportunities for employment in the U.S.

Extended or nuclear family: Mrs. Rodriguez lives with her nuclear family and does not see her extended family on a regular basis. If diagnosed with HIV, Mrs. Rodriguez's extended family may not be close enough to depend on for a support system.

Ethnic behavior: Mrs. Rodriguez mentioned that she was celebrating *el Día de los Muertos* (The Day of the Dead) with her family in Mexico. This is a huge celebration in Mexico and several other Latin American countries that involves parades, music, special food, and other festivities. The celebration is in honor of dead loved ones and occurs during the first two days of November.

Time living in the United States: Mrs. Rodriguez has lived in the United States since she was 12 years old. Although she may be somewhat acculturated to the mainstream U.S. culture, she also likely possess many aspects of her native Latino culture.

During the Encounter

During the clinical consultation, the provider should be aware that in terms of patient behavior, Latinos might convey a myriad of styles regarding responses to health-related questions. When asked direct questions that are sensitive, it may take time for Latino patients to think through and answer a question that requires an overtly direct reply. Chong (2002) has offered two possible cultural explanations for this response style. First, Latinos consider health care professionals to be very experienced and knowledgeable and may expect them to be able to diagnose their health problems without much assistance on their behalf. Second, the patient may not want to answer or ask direct questions because he or she may be afraid to find out about a severe illness like HIV/AIDS.

Another culturally relevant factor for providers to remember is that Latinos communicate through physical contact and appreciate physical closeness. A provider should greet a Latino patient with a handshake at the initial clinical encounter and offer a handshake upon completion of the encounter (Chong, 2002). Providers must be active listeners when their Latino patients are providing information and should be able to prompt their patients with follow-up questions. This will assure patients that their medical providers are listening and are concerned. Providers must avoid displaying judgmental attitudes, particularly if patients discuss cultural beliefs and/or use of folk medicine, as this will likely evoke a negative reaction from the patient and impede the establishment of *confianza*.

Interviewing the Latino Patient

There are two important aspects in developing a consult: (1) how to begin; and (2) how to maintain a dialog under time constraints. In an effort to avoid potentially unrelated answers to open-ended questions, it may be useful to ask more direct questions while showing a genuine interest in the patient's response. This approach may produce answers that are more direct; however, the provider needs to carefully weigh the potential loss of *confianza* that could have been formed through the process of patient sharing. If the provider appears rushed or uncaring, vital patient information may be lost and the overall encounter can be much less effective for both the patient and the provider. Many providers find that an initial time investment to develop *confianza* and *respeto* saves a great deal of time later and can help prevent improper diagnosis and treatment.

Although time is of prime importance in the current U.S. health care setting, Latino patients, particularly immigrants are accustomed to medical settings wherein substantial time is afforded for patient-provider interactions. Physicians normally meet patients in their offices first and then move into the examination room, only after being fully briefed about the reasons for the patient's visit. It is not uncommon for a physician to treat an entire family and to inquire about various family members during a patient's medical visit. Although providers in the United States may be unable to replicate these interactions, particularly due to time constraints, it is beneficial for providers to be aware of what their Latino patients may be accustomed to, and to attempt to compensate for the short period of time that they are allotted to examine each patient. Providers must constantly work to establish a delicate balance between adequate communication and the severe time constraints posed by our current medical system.

Immediate inquiry as to the reason for a patient's visit is not the best approach for eliciting information. In Latino cultures, such a direct and to-the-point question is often considered improper and may suggest a lack of personal interest on behalf of the provider or a desire to conclude the appointment rapidly. The patient may resent such behavior and, although it may not be evident due to a polite attitude on behalf of the patient, any further attempts at connecting with the patient may prove unsuccessful. This can be frustrating for a non-Latino provider if the reason for consultation seems to emerge only at the end of the interview; however, this can result in a more effective encounter and can increase the efficiency of future visits (Chong, 2002). It is essential for the provider to understand this point and, particularly in the case of a recent immigrant, allow for brief conversation related to the patient's personal health care experience in traditional and/or non-traditional systems before directing the conversation to the reason for the consult. The provider should try to understand the point of reference and the health care experience of the immigrant patient in his or her home country in order to curb the development of any obstacles to patient-provider understanding and *confianza*.

Clinical History

Personal Data

When inquiring about nationality, it is usually acceptable to ask the patient about his or her place of birth as this is a source of pride for most Latinos (Chong, 2002). Questions related to the legality of immigration status should be avoided in order to help build and maintain *confianza* with the patient and to create a comfortable environment.

History of Current Health Problems

An understanding that a patient's health beliefs and practices are part of the patient's reality is critical for the provider. When the patient is discussing health-related problems, the provider can pay special attention to problems specific to current ailments and prompt the patient with follow-up questions. Failing to consider the patient's cultural beliefs may result in a patient who shows little or no commitment to the treatment plan (Chong, 2002). It may be possible for the provider to prescribe a medical regimen that allows the patient to continue using non-standard "folkloric" forms of treatment along with that which is prescribed by the provider as long as the non-standard treatment is harmless to the patient. By allowing the patient to incorporate his or her own cultural beliefs into the medical regimen, the provider can increase the Latino patient's adherence to prescribed treatments (e.g., antiretroviral therapy). Providers should also be aware that Latino patients may use metaphors to help illustrate the level of pain they are experiencing (Chong, 2002).

Past Medical History/ Family History

Once *confianza* is established, the Latino patient will likely spend time describing previous ailments in great detail. Discussing past ailments may provide a starting ground for the development of a good patient-provider relationship. Facing current health problems can generate uncertainty and fear; however, discussing previous problems should prove more comfortable for the Latino patient (Chong, 2002). Topics related to previous surgeries, illnesses, allergies, and medications typically present few cultural issues for the Latino patient, with the exception of conditions related to sexual or reproductive health, which may result in embarrassment. This may also apply to questions about family history. The Latino patient may be less likely to disclose a personal or family history of HIV/AIDS or other STIs. A Latino's age, generation, and level of education play a major role when reporting information about personal or family medical history to a health care provider (Chong, 2002).

Cultural Practices (May Be Covered in Past Medical History)

When asking about health habits and diet, the provider may want to be aware of the methods of preparation and the types of ethnic foods the patient typically prepares and consumes. These may need to be altered to enhance health status, particularly if there are

potential interactions between treatment regimens and certain types of foods that could pose a risk of bacterial infection. For example, it may be necessary for an HIV positive patient to avoid *ceviche* (raw fish marinated in lemon or lime juice) due to the risk of bacterial infection (Scolari, 2004). Additionally, alcohol and tobacco use must be carefully monitored in terms of type, quantity, frequency and method of consumption. Alcohol and/or tobacco may be used in higher frequency during festive events and traditional holidays.

Monolingual patients who are recent immigrants may have had little access to Western medical health care and may rely solely on folk remedies and traditional methods of healing. Recent immigrants may also believe in the elements as factors in disease causation, such as wind (*me pegó un aire*). In addition, evil eye (*mal de ojo*) and other folk illness beliefs may play a considerable part in the patient's health belief system. Provided that these beliefs do not cause harm to the patient and do not disrupt treatment, health care providers should work to understand the underlying rationale and integrate these beliefs into a treatment protocol that is inclusive of the patient's culture.

Sexual Health History

There are a number of cultural issues regarding sexual activity that may make Latino patients uncomfortable and thus reluctant to discuss. Homosexuality is not well received in the Latino community and as a result, homosexual patients may not be willing to disclose this information for fear of stigmatization. This can be frustrating for health care providers who are attempting to collect information about HIV risk behaviors from Latino patients who may engage in homosexual activities (e.g., anal sex) but do not self-identify as homosexual. It may take several office visits with the patient before *confianza* is established and the patient is ready to voice his or her concerns with a health care provider. Additionally, the style of questioning used by the provider should vary depending on the type of response elicited by the patient. Providers may use a third person approach in their questioning, such as, "Some people have contracted HIV during have you ever participated in this activity?" Using the third-person approach can be an effective alternative to direct questioning to elicit sexual health information from a Latino patient.

Conclusion

The important points to remember in conducting a clinical encounter with a Latino patient are:

- A handshake is expected at the initial clinical encounter and at the end of the interview by both male and female Latino patients.

- Making eye contact with Latino patients is critical; however, gender differences between patient and provider helps define appropriate eye contact.
- Latino patients appreciate providers who greet them with a warm, friendly, and moderate tone of voice.
- Unless a provider is fluent in the patient's language, a trained interpreter should always be utilized.
- When using an interpreter, the triangular approach should be used to ensure that the patient, provider, and interpreter are all facing each other (eye contact should be maintained primarily between the patient and provider).
- During HIV/AIDS related encounters, providers should listen actively and display a nonjudgmental attitude.
- Providers should consider the elements of the GREET approach which include: **G**eneration, **R**easons for immigrating to the United States, **E**xtended or nuclear family, **E**thnic behavior, and **T**ime living in the United States.
- *Confianza* (trust) is a vital part of an effective patient-provider relationship.
- Being aware of cultural practices can improve a provider's ability to communicate and effectively treat Latino patients.

References

- Chong, N. (2002). *The Latino patient: A cultural guide for health care providers*. Yarmouth, ME: Intercultural Press.
- Cross Cultural Health Care Program. (2004). *Medical interpreter code of ethics*. <http://www.xculture.org/interpreter/index.html>.
- Falcón, A., Aguirre-Molina, M., & Molina, C. (2001). Latino health policy: Beyond demographic determinism. In M. Aguirre-Molina, C. Molina, & R. Zambrana (Eds.), *Health issues in the Latino community* (pp. 3-22). San Francisco: Jossey Bass Publishers.
- Lecca, P., Quervalu, I., Nunes, J., & Gonzales, H. (1998). *Cultural competency in health, social, and human services: Directions for the twenty-first century*. New York: Garland Publishers.
- Scolari, R. (2004, June). *Continuum of HIV services for hard-to-reach Latinos/as, including nutrition counseling*. Presentation at National Council of La Raza Annual Conference, Phoenix, AZ.
- U.S. Census Bureau. (1993). *We the American ... Hispanics*. Washington, D.C.

Conclusion

Effectively treating the Latino HIV/AIDS patient requires a commitment to culturally competent care. Culturally and linguistically competent care will aid in the elimination of current health disparities and increase positive patient outcomes. This book provides information on six culturally relevant elements that affect Latino patients with HIV/AIDS: Barriers to Care, Ethics, Sensitivity of the Provider, Assessment, Facts, and Encounters. The information provided in the Latino BE SAFE Model can be used as a guide for health care providers who wish to increase their knowledge about Latino culture and issues facing Latino patients with, or affected by, HIV/AIDS. The Latino BE SAFE model can serve as an effective tool to increase the capacity of health care providers to treat Latino patients with, and at risk for, HIV/AIDS.

While it is good to learn some specifics about the Latino culture, health care providers should remember that the Latino population is very diverse. Providers must be cautious of stereotyping Latino patients and should remember that individual experiences will cause each patient to have their own unique, idiosyncratic culture. Providers who are committed to providing culturally competent care will strive to maintain an open and understanding attitude toward their patients' cultural beliefs, values, and backgrounds, and will make efforts to treat each and every Latino patient with the respect they deserve. The process of "becoming" culturally competent is a continuous one learning progression, and for this reason, each patient-provider interaction should be viewed as an opportunity for increased learning. Culturally competent providers may choose to serve as advocates for the Latino population and work to assure that sufficient resources for HIV prevention and management are allocated for Latino specific efforts.

It is the hope of the contributors that this document serves merely as a first step for providers seeking to better the quality of care they provide for the Latino population infected with, and affected by, HIV/AIDS. We congratulate the readers for their interest and commitment to improving health outcomes of Latinos. NMAETC and the NCLR welcome feedback and pertinent comments related to this manuscript and culturally and linguistically competent strategies to improve HIV/AIDS related care for Latinos.

According to the U.S. Census Bureau, by the year 2050, Latinos will represent over 25% of the U.S. populace. It is those providers who have embraced this diverse population who will best be known for their ability to affect the overall health of the United States. Emerging pop-

ulations of Latinos throughout the U.S. are increasingly in need of culturally and linguistically appropriate HIV-related prevention information and management education. In the development of such materials, literacy level must be carefully adjusted to meet the diverse spectrum of educational levels within Latino communities.

The Latino population overall has demonstrated amazing levels of resilience in the face of numerous barriers to health care, and this is perhaps most clearly demonstrated through the daily lives of the many Latinos living with HIV/AIDS. As this population continues to experience increases in HIV infection that surpass all other racial and ethnic groups, immediate attention and resources must be allocated to better define and target HIV risk and barriers to HIV/AIDS management within these communities. It is essential for providers to recognize that Latinos present with a unique HIV risk profile. As an increasing number of States in which large populations of Latinos reside begin to publish data on new HIV infections, a clearer description of causation will arise. Models that explain health-related behaviors among Latino populations are sorely lacking mainly due to the historical, political, and economic neglect that has defined the experience of the majority of Latinos in the United States. If problems associated with HIV and AIDS are to be effectively addressed within the largest minority population in the United States, the public health and human service community must strive to better illuminate and reduce the numerous factors that impact the contexts of HIV risk and problems of HIV/AIDS management in the Latino community.

Appendix: Case Scenarios

Case Scenario 1:

Maria, a 42-year-old Latina, reported for the results of her HIV test a month after being tested. Maria is not fluent in English so she brought her two teenage sons, Miguel and Javier, to help translate for her. The clinic does not have bilingual staff or hired interpreters, so when Miguel explains that he and his brother will translate for their mother, who is not proficient in English, the clinic staff does not oppose this arrangement. While the counselor feels uncomfortable about sharing the results of Maria's HIV test with her two sons, the counselor proceeds to do so because she knows of no other way to communicate the results to Maria. As the counselor begins to inform the sons that their mother has tested positive for HIV, Javier becomes very upset and starts crying. Miguel translates the results to his mother and begins accusing her of sexual promiscuity.

1. What could have been done differently to prevent this situation from occurring?
2. If placed in a similar situation and lacking a certified interpreter, what are some options for overcoming language barriers in a culturally sensitive manner?
3. Is it ever appropriate to ask or allow a patient's family members to serve as interpreters, and if so, should the age and gender of family members be taken into consideration?

Case Scenario 2:

Carmen, a 17-year-old Latina, shows up at a clinic for a gynecological exam. Carmen has been sexually active for over a year, and because she does not use condoms consistently, she is afraid that she may have contracted HIV or another STI. Carmen's mother has insisted on accompanying her to the exam, which she believes, is only to discuss an irregular menstrual cycle that Carmen has been complaining about. When the provider asks Carmen if she would like her mother to stay for the exam, her mother says, "Of course she would, she has nothing to hide from me." As the provider begins to ask Carmen questions related to her sexual health, it becomes obvious that Carmen is uncomfortable answering the questions in front of her mother. When the provider asks if Carmen has ever engaged in sexual intercourse, Carmen glances over at her mother and then responds "No, of course not." Carmen desperately wants to voice her concerns about the possi-

ble contraction of HIV or another disease but she is ashamed to admit to her mother that she has been sexually active, and therefore does not request the appropriate medical screenings.

1. What cultural beliefs and values contribute to Carmen's unwillingness to admit her sexual behavior in front of her mother?
2. How could the health care provider request that Carmen's mother leaves the exam room without offending her or implying that Carmen is hiding something from her?
3. How could the provider successfully address Carmen's health concerns and provide Carmen with sexual health information without causing a great amount of family discord between Carmen and her mother?

Case Scenario 3:

Alex is a 26-year-old Latino who has been married for eight years. He has a wife and three young children. He is returning to the clinic for his first follow-up visit after receiving an HIV diagnosis the previous week. Upon interviewing Alex, the provider asks him if he has shared his diagnosis with his family and if they have been tested. Alex responds that he has not shared the information about his HIV status yet because he is afraid that they will reject him. Further discussion about how Alex contracted HIV reveals that he has been engaging in unprotected anal intercourse with other men in the evenings when he gets off work. He self-identifies as heterosexual and says that he only has sex with men because it is something new and different, not because he is attracted to men. He says that he loves his wife and his children very much, and that he does not want to hurt them.

1. What are some Latino cultural values that the provider could address in order to persuade Alex to share his diagnosis with his wife and family?
2. What is a Latino cultural value that may attribute to Alex's refusal to self-identify as bisexual or homosexual?
3. How can the provider respond to Alex's confessions of homosexual behavior in a culturally competent fashion?

Case Scenario 4:

Antonio is a 32-year-old Latino who has been living with HIV for the past 6 years. Antonio has lived in the United States for 17 years, although all of his family still lives in Guatemala. When he

shows up for treatment, his health care provider realizes that Antonio has not been adhering to his treatment regimen and that his viral load is increasing. Antonio tells the health care provider that he has had severe diarrhea ever since he returned from visiting his family in Guatemala and his condition prompted him to seek treatment. He informs the health care provider that he has been praying several times a day and receiving limpias (spiritual cleansings) from a curandero (folk healer) who lives nearby; however, he does not seem to be feeling any better. When the health provider asks why Antonio has not been adhering to his treatment regimen, he responds that he is afraid of the harmful side effects that the drugs may have on his body.

1. Is Antonio at increased risk for an opportunistic infection? If so, why?
2. How could Antonio be affected by living in isolation from his family members? Could this have a negative impact on his adherence to his treatment regimen?
3. How could the health care provider integrate Antonio's use of folk medicine practices into his prescribed treatment regimen to produce better health outcomes for Antonio? How could the provider find out more about Antonio's folk medicine practices to ensure that they are not harmful?
4. What are some culturally competent approaches the health care provider could use to address Antonio's concerns about potential side effects from prescribed medications?

Glossary

Acculturation—cultural modification of an individual, group, or people by adapting to, or borrowing traits from another culture; a merging of cultures as a result of prolonged contact

Anticuerpos— Spanish for “antibodies”

Botanicas—herbal and spiritual pharmacies and/or stores

Boticas—pharmacies found in Latin America, the Caribbean, and Mexico, where Western medical treatments and homeopathic remedies coexist

Caida de Mollera—fallen fontanelle; a Latino folk illness that affects babies; symptoms include crying, irritability, inability to suck, vomiting, and diarrhea; caused by pulling a baby away from the breast or bottle too quickly, dropping a baby, or carrying a baby incorrectly

Castigo divino—divine punishment

Células T—Spanish for “T-cells”

Ceviche—raw fish or seafood marinated in lemon or lime juice

Confianza—trust resulting from mutual respect and concern

CLAS Standards—culturally and linguistically appropriate mandates, guidelines, and recommendations issued by the Office of Minority Health, U.S. Department of Health and Human Services, and intended to guide practices related to culturally and linguistically appropriate health services

Cultural Competence—a set of congruent behaviors and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations

Culture—the thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups

Curandero—Latino folk healer

Curanderismo—Latino practice of using *curanderos* (folk healers) to cure illnesses through herbal or spiritual therapies

Empacho—gastrointestinal obstruction; a Latino folk illness that affects all age groups; symptoms include anorexia, vomiting, diarrhea, indigestion, bloating, and constipation; caused by a bolus of

undigested or uncooked food that has stuck to the wall of the stomach or intestine

Espiritismo—folk practices influenced by Spanish, European, African, and Indian elements; the central premise of *espiritismo* is that material and immaterial objects are inhabited by good and evil spirits that have the power to influence human thoughts and behaviors

Ethnicity—a population's or group's common cultural heritage, distinguished by such characteristics as norms, language patterns, values, and beliefs

Ethnocentrism—the tendency to interpret or evaluate other cultures in terms of one's own cultural standards; interpreting one's own group/culture to be superior

Fatalismo—the belief that one must passively accept the unfortunate events in one's life and the belief that one has little control over negative health outcomes

Familismo—the reliance of the individual on the family network for social support

Infecciones Oportunistas—Spanish for “opportunistic infections”

Infectar—Spanish for “to infect”

Limpias—spiritual cleansings usually performed by *curanderos* or *sobadores*

Linguistic Competence—providing readily available and culturally appropriate oral and written language services to limited English proficiency speakers through trained medical interpreters and qualified translators

Mal de Ojo—evil eye; a Latino folk illness that primarily affects children; symptoms include crying, restlessness, fever, and vomiting; caused by someone with a “strong eye” who looks at or admires a child too strongly

Mal Puesto—a Latino folk illness that affects all age groups; symptoms include sudden attacks of screaming, crying, singing, convulsions, and uncontrollable urination; caused by an evil hex

Machismo—refers to the traditional gender role of the male Latino; encompasses the qualities of virility, sexual prowess, strength, independence, bravery, complete decision-making power, and an obligation to love and protect one's family

Marianismo—refers to the traditional gender role for female Latinas; encompasses the qualities of chastity, virginity, abnegation, sacredness, devotion to home and family, and self-sacrifice in the interests of the family

Personalismo—warmth, friendliness, and physical closeness resulting in a warm and personal relationship

Race—a local geographic or global population usually distinguished by genetically transmitted physical characteristics

Respeto—respect for others, particularly elders and authority figures

Sangre—Spanish for “blood”

Santeria—folk practices with roots in African religion and Catholicism; a belief that the worshiping of saints can be exchanged for supernatural powers and protection

Sexo Anal—Spanish for “anal sex”

Sexo Oral—Spanish for “oral sex”

Sexo Vaginal—Spanish for “vaginal sex”

SIDA—Spanish for “AIDS”

Simpatia—the quality of being friendly, polite, and pleasant with an edge of humility and vulnerability

Sistema Inmunológico—Spanish for “immune system”

Sobadores—Latino masseuse or masseur

Susto—fright sickness; a Latino folk illness that affects all age groups; symptoms include lethargy, anxiety, depression, insomnia, and irritability; caused by a frightening or traumatic experience

Transmitir—Spanish for “to transmit”

VIH—Spanish for “HIV”



National Minority
AIDS Education and Training Center

Produced in collaboration with
the National Council of La Raza

NCLR
NATIONAL COUNCIL OF LARAZA

Supported by a grant from HRSA HIV/AIDS Bureau,
Health Resources and Services Administration
HRSA Grant No. 6 H4AH00066-02-01

For information on programs and offerings
please visit our website: <http://www.NMAETC.org>