
Issues of Women and Girls, HIV/AIDS and Immigrants

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I.

Introduction – *Two Strategy Meetings*

In response to the annual call by the United States Department of Health and Human Services, Office on Women’s Health to recognize *National Women and Girls HIV/AIDS Awareness Day*, a luncheon meeting was held in New York City on March 10, 2010. It was decided by the attendees to have a follow up meeting which was held on July 13, 2010. Both meetings were held at the Conference Center of the Community Resource Exchange(CRE). Individuals, representatives from community based organizations in fields such as health and mental health, HIV/AIDS, social service or domestic violence, a few of whom are infected by HIV and government officials from the Federal (Region II and National), State (New York State AIDS Institute) and City, New York City Department of Health and Mental Hygiene attended the meetings.

* For a complete list of participants, please see Appendix page 28.

Summary of the Purpose

The specific focus of this *first* meeting ever held in New York City since the beginning of the HIV/AIDS epidemic to address the intersection of *Women and Girls, HIV/AIDS and Immigrants* had two goals. The goals were, number one, to examine the obstacles to prevention and care and number two, to make recommendations on how best to overcome them. Included among the many obstacles experienced by the immigrant women at the meetings or told to them by their clients which impact and influence HIV infection are economic security, children and family structure, immigration policies and existing laws, incarceration, language, stigma, healthcare, supportive services, traditional cultures, personal faith and spirituality and religious groups.

II.

The Context-Overarching Issues

Every thirty five minutes, a woman in the United States tests positive for HIV. About one in four Americans living with HIV infection are women, as reported by the Office on Women's Health.

A commonality among immigrant women includes being in a new country with a language difference, often limited in education and with limited skills. Low self-esteem and a sense of hopelessness can make immigrant women most vulnerable to mental health problems, victims of violence, turn to the sex trade as an economic response, as well as their hunger for love and acceptance. Many of the women have identity and gender issues addressing their own identity such as being multi-racial, their sexual orientation and knowledge, and gender issues including an inability to discuss homosexuality and transgender.

When trying to get an accurate picture of people who are HIV infected, there are complications including:

- the lack of English proficiency,
- the lack of trust towards unknown social service, medical and legal personnel,
- stigma, and the loss or fear of a loss of confidentiality.
- The lack of any, or limited knowledge of immigration laws or any of the above mentioned issues affects the way answers are given, making it particularly difficult when speaking with immigrants who are conscious of the effect and importance of their answers on their immigration status.

Overarching issues such as:

- poverty and its relation to employment,
- English proficiency and the level of education received in their home country or in the US;
- when and at what age a person immigrated to New York State or City;
- was entry into the US with birth family members, alone, as an orphan, or part of a foster

family resulting from war, famine or family problems and sometimes trauma due to the socio/economic/political situations left behind, impact the chances of becoming infected with HIV and the choices that are made to survive.

- ♦ There is a high level of being unsure of what they will face in the US.
- ♦ Health care in this country is more complicated and the ever evolving US national health care systems differ from state to state and in local jurisdictions.
- ♦ The immigration laws, written in English, which are also evolving, now under the Department of Homeland Security in the Division of Immigration and Customs Enforcement, known as ICE, are formidable to people who fear authority figures who usually speak to them in English which is not their language of comfort or competence.
- ♦ National laws affecting both immigration and health care access and regulations, also written in English, often present dilemmas and in the context of HIV/AIDS are far greater than local jurisdictions can solve alone, yet until the changes in national public health policies are made, time will continue to take its toll upon immigrant women, girls and their families.

III.

Background Data for New York State and New York City

New York State (NYS)

According to the US Department of Labor (USDOL), 2000 Census, 20.4% of New York State's population, males and females were foreign born. ICE estimated that as of February 2003, the January 2000 undocumented immigrant population numbered 489,000.

According to the NYS Department of Health, AIDS Institute, 99,521 were living with HIV at year end 2003 as reported through January 4th, 2005:

- 15,669 have no country of birth.
- 16,143 are missing a place of birth.
- 70% are US born, 11% foreign born with 19% unknown place of birth for a total of approximately one-third of People Living With HIV/AIDS (PLWHAs) having limited data.
- The eleven countries (through January, 2005) with the highest number of immigrants who reported their country of birth and source of infection were: Haiti, Dominican Republic, Jamaica, Colombia, Mexico, Trinidad and Tobago, Ecuador, Guyana, Brazil, Peru and India.
- Puerto Rico (3,565), the US Virgin Islands (41) and one each in American Samoa, Guam and the Pacific Trust Territories are included in data as American born, not foreign.

New York City

The USDOL 2000 Census reported that 36% of New York City's population is foreign born. 3 million of NYC's 8 million residents were born outside of the US as reported to the NYC Department of Health and Mental Hygiene (NYCDOHMH) by September 30th, 2009, of the 3,809 New York City residents diagnosed with HIV in 2008:

- 1,062 people (27%) were foreign born, 5% were from Puerto Rico, the US Virgin Islands, US Samoa and Guam and the Pacific Trust Territories, 11% unknown and 56.1% US born.
- Newly diagnosed foreign born by region of birth in 2008 were 34% -from the Caribbean (excluding Puerto Rico and the US Virgin Islands), 18% Central America, 17% Africa, 15% South America, 7% Asia, 6% Europe, 2% other not specified and

- ♦ 1% Middle East. Because of the small numbers, the Middle East's 23 newly diagnosed included a combined total from 2007 and 2008 of whom 17.4% were concurrently diagnosed with AIDS.

Of the eleven highest countries, where New Yorkers were infected are, in descending order: Dominican Republic, Mexico, Jamaica, Haiti, Colombia, Trinidad and Tobago, Guyana, Honduras, El Salvador, China and Cote D'Ivoire.

Using updated United Hospital Fund boundaries, of the HIV+ immigrants (from 2004 to 2008) 1,976 persons were reported born in the Caribbean, and 1,668 from Central (including Mexico) and South America:

- ♦ Brooklyn: *Flatbush /East Flatbush* had the highest with 349 cases (18%) new diagnoses born in the Caribbean.
- ♦ Queens: *West Queens* had the highest with 317 (31%) born in Central and South America.
- ♦ Transmission risk of new diagnoses among males were:
 - Non-foreign born (N=1,466) 81.9% MSM, 10.7% IDU, 7.0% heterosexual
 - Foreign born (N=508) 81.3% MSM, 3.1% IDU, 15.0% heterosexual
- ♦ Transmission risk of new diagnoses among females were:
 - Non foreign born (N=487) 11.5% IDU, 87.7% heterosexual
 - Foreign born (N=251) 99.2% heterosexual

IV.

Goals and Objectives of the Meetings

Format – Meeting One

To maximize the limited discussion time for the first meeting, the participants were divided into five groups. Each group was seated around a round table. An attempt was made to have each group as diverse as possible, with community members and government members from each level of government. Moderators and note takers were appointed for each table. The facilitator from the Community Resource Exchange (CRE), Barbara Turk, asked each participant to state name, title and name of organization or agency if any and population served. A short welcome was given by Christopher Bates, the Executive Director of the President's Advisory Council on HIV/AIDS (PACHA) and Senior Health Program Advisor to the Office of Public Health and Science of the Department of Health and Human Services. He explained the creation of the National Recognition Days one of which, the Day for Women and Girls was being recognized and the reason for the meeting. Fran Barrett, Director of CRE welcomed the group and invited the group to use CRE space whenever needed.

Barbara Turk then explained the format for the meeting. Each table would discuss the problems faced by immigrant women and girls, to which the government participants would listen. The second half of the discussion would be to develop policy recommendations to try to solve the issues and problems to which the government attendees would continue to listen. When the time was up, each table gave a brief oral report of the problems and the solutions they came up with. The group was quite surprised at the similarity of each group's report. Christopher Bates stated that on nationwide trips convened by PACHA to hear what local jurisdictions were feeling, the reports from each table echoed the sentiments he had heard throughout the country. He encouraged the group that it would be of interest to have the group meet again and to share the findings in a final report. He stated that he was sure the Region II office would provide any logistical help needed for the second meeting. Each recorder was asked to e-mail their notes to the facilitator who would then provide them for this report. The group decided that they would like to have a second meeting at which all of the assembled notes would be consolidated and shared. The document would be reviewed and organized for a final report which would then be made available to all participants to share and disseminate. This report represents a distillation of the discussions at both meetings

Format – Meeting Two

- each participant was given a copy of the draft to read.
- around a hollow square, all participants sat face to face to discuss the draft .
- it was decided that it would be most strategic to organize the results of the first meeting by issues

Part One – Each of the Issues Faced by Immigrant Women

Part Two – Recommendations to Address Those Issues

The informal discussion was facilitated by Soraya Elcock with all of the suggestions discussed and accepted by consensus.

Regardless of immigration status, it is common for women to focus on meeting immediate needs such as housing, care for their children and other family members, work commitments with economic status rather than consideration of their own health, including a prioritization of HIV.

- It is crucial for women to receive holistic care and information
- There must be a paradigm shift in reframing the message to recognize women as gatekeepers, enjoying womanhood rather than just being caregivers on duty 24/7.

Each of the major issues raised by the group were those most frequently mentioned in the first meeting and caused the most concern. Many immigrant women do not know the immigration policy “rules and procedures” and with their limited education, believe the stories they hear from others who build upon their fears.

IV.

Issues Facing Immigrant Women

Among the issues faced by women, with a heightened concern by immigrant women because of their status (and sometimes it doesn't matter if they are documented or not) are:

1A. Language Barriers

- Women are ashamed to admit their lack of English ability-both oral and written.
- This shame causes some women who don't understand what is being said to just haphazardly smile or say yes or no.
- It is unknown to a majority of women that translation is often mandated and they are entitled to request translation in medical or legal settings.;
- Some women are not literate in their own language so when presented with translated materials they are unable to understand and interpret the information.;
- Often times women use children, other family members or friends to translate information, which can result in misinformation and embarrassment due to the subject matter. Personal issues are sometimes not answered or are not answered truthfully;
- Often the translator, not being trained in health matters cannot understand what is being said or interprets the question and or the answer information incorrectly;

Medical providers also play a role in creating barriers in communication for clients.

- Prevention and care messages and steps are not always written in a manner that is easily readable and understood.
- Important care messages (i.e. medication directions) are not always written so women can understand them. As a result, patients are blamed for not following directions, or for missing appointments and this often happens because they have not understood.
- Some medical professionals also do not take the time to find interpreters and translators.

- ✦ Medical professionals may have difficulty addressing issues of the patient's culture and language which they do not value and respect, further adding to the embarrassment of patients. Cultural values and beliefs often prevent talking about sex and sexuality, illness, and death. These matters are deemed to be private or should stay in the family.

1B. Recommendations for Removing Language Barriers

- ✦ Increase diversity of language in signage.
- ✦ Increase access to translators and interpreters.
- ✦ Provide information in all languages of patient population.
- ✦ Provide notice of patient's rights to translators in their own language to take home.
- ✦ Inform patients of sources for translators and that family members are not recommended – stressing privacy.
- ✦ Prior to a patient leaving any session, be sure the patient understands when and where the next appointment is. If there are special directions for not eating or having anything to drink before tests be sure the patient understands. It must be written down clearly and in large print. Some countries put day then month, or year first, so write out the month and day. Have the patient repeat the information so that the clinician knows the information is correctly understood.
- ✦ Executive Orders must be put into place so that funds will be provided to create medical setting translators and interpreters. When these are established, funds must be allocated for ombudsmen programs to ensure accountability and meeting high standards.
- ✦ Medical Schools, Nursing Schools, Schools of Social Work, Accounting/Medical Business Schools and Law Schools must be mandated to:
 - provide cultural competence courses so that all staff interfacing with patients and families receive this information.
 - offer accreditation courses in medical translation for all medical settings.
 - offer special incentives for students to take courses in medical translation. If federal money is provided to schools it should be a requirement for continued funding.
- ✦ Personnel who have graduated prior to the provision of these mandates, must take a course for recertification.
- ✦ Develop partnerships with local English as a Second Language Classes to enable patients to develop English proficiency. This could be a new opportunity for other immigrants to get recognized for their native language ability.

2A. Immigration Policies and Existing Laws are Barriers to Care

There is confusion among many women about green card eligibility and HIV status. This confusion includes having inaccurate knowledge about what the green card means and entitles someone to. Programs need to provide an abbreviated course for women in their own language about green cards and what HIV actually is besides a set of initials. Recent changes in eligibility regarding immigration and HIV need to be clarified so individuals are not given the wrong information. All women need to have this information, including recent immigrants and immigrants who may have resided here for a lengthy period but have never had the opportunity to receive correct information in their own language.

- ✦ While it may difficult to find or identify, every attempt must be made to include lesbians, transgenders and the undocumented to receive all information provided to documented immigrants and to be included when it is possible to identify.

Because many immigrants consider America a temporary home and want to return to their own country they are often willing to endure hardships to achieve their goal of saving enough money. Others change this goal and decide to stay here and bring family members here. In any case, they often have a mistrust of government based on the socio political issues experienced in their home country.

Immigrants need legal services and translation of information to help maintain a better quality of life, without fear of the “unknown.” To overcome these difficulties, local community groups that provide social services, legal services groups and assistance provided at places like settlement houses need funding to provide assistance where immigrants have:

- ✦ Lack of knowledge about ICE and immigration laws,
- ✦ what immigration status entitlements include in regards to health, emergency, pregnancy and infant care for women including lesbians or transgender. Ignorance can have a negative impact on their lives. These sensitive issues need to be translated appropriately.
- ✦ Because each jurisdiction has different sets of regulations for obtaining health care, patients often wait until there is an emergency to access information.
- ✦ Every health facility must have an emergency translation system in place with all personnel (on a 24 hour basis and including weekends) trained in its use.
- ✦ Immigrants can have a lack of knowledge about emergency care, including pregnancy, infants, poison, breathing difficulties etc. These items should be translated and available as a written document as well as a video or some oral version.
- ✦ Lack of trust of immigration officials sometimes gets people into situations which could have been handled prior to problems developing. Some immigrants developed a mistrust

of government based on socio political issues experienced in their home country and have transferred it here.

2B. Recommendations for Removing Barriers Due to Immigration Policies

- ✦ Immigrants need information upon entry to the country about regulations and emergency care and access to emergency – medical, fire and police written in their own language.
- ✦ Immigrants need access to legal assistance that is free, or based on ability to pay and in their own language.
- ✦ Legal service organizations need to be funded to provide practical assistance and courses for immigrants on their rights.
- ✦ Graduate Schools including Medical, Law, Social Work must provide a basic course in immigration laws and confidentiality so that practitioners can provide up to date informed quality care. Because of confidentiality issues every effort must be made IN THEIR OWN LANGUAGE to reassure people that their information will be protected and that any information does not go to ICE.
- ✦ Identify and consider best practices used by international programs such as WHO, PEPFAR, and NGOs from other countries, to see how HIV/AIDS programs overseas can be used to help immigrants and their communities in the US.

3A. Access to Care (Lack of) as a Barrier for Immigrants

Women are frequently entering care at a later stage of HIV or when presented with other diseases and conditions. Patterns of care and taking medications are inconsistent and many are under or uninsured. Care is not sought until symptoms are presented and at that point they often do not know the appropriate place to go for the services. The emergency room at hospitals is used for episodic care due to lack of information of other programs and resources but it is also used for anonymity purposes.

Caring for their families is paramount in their lives. Women are the glue that keeps the family together with no help from others. Their own health is ignored because the needs of family come first.

Fear plays a major factor in the decision making process. Immigrant women:

- ✦ Are afraid to get care for fear of losing a job and income.
- ✦ are afraid to be hospitalized in fear of having the illness reported to ICE
- ✦ Are afraid to leave children if they are hospitalized
- ✦ Use the emergency room at hospitals because they assume there is anonymity there

- Have limited sources for help getting care for adults and children
- Lack of insurance
- Language is a barrier when getting directions for type of care and sources for specialty needs.

3B. Removal of Lack of Access to Care as a Barrier for Immigrants

- Upon entry to this country information about emergency care, health care regulations must be provided in their language. This material should also be available at not for profit, legal offices and community centers, for easy access of people who may not have entered with papers.
- Immigration officers must be trained to provide quality of life information in a courteous manner that includes health care, legal services and immigration rules to help to begin to remove the fear of government authority figures as not being helpful.
- Churches, mosques, temples, synagogues and store front places of worship must be provided information about immigration in relation to access to health care and places to access and care for all family members.
- Personnel from religious organizations should be offered courses in how to help immigrants with legal and medical problems.

4A. Economic Insecurity as a Barrier to Care

Socio economic conditions put women at risk for HIV infection if they have a limited education, low skill level, live at poverty levels and are the sole supporter of her family, often working several jobs.

As sole supporters of their families, women are responsible for all aspects of educating their children. Raising the issue around HIV/AIDS creates a whole constellation of issues. Children including adolescents are at risk for infection because they themselves are sexually active and sometimes have multiple sex partners. Cultural issues prevent conversation about sex and sexuality to take place with another sex or other generations as well as a discomfort about what is deemed to be a private topic. It is often believed that teens already have the information or that they should not be engaging in sexual activity, so parents don't talk to their children about sex, sexuality and HIV prevention. Young people are not provided a routine sexuality education or disease prevention in school so that many young people pass incorrect or incomplete information to each other.

All school systems must teach health including reproductive rights, domestic violence, sexuality including HIV/AIDS.

Acculturation and traditional family values are/may not be similar to those in the US. This creates a wide range of interrelated issues and problems because education is necessary for economic stability, yet if that does not include HIV prevention it places all of the family at risk. Coming to America may have created massive problems for families used to particular traditions and a culture which is economically, politically and socially literally oceans apart.

If a partner has been incarcerated in the country of origin or the US it creates a problem for the family economically as well as socially.

The situation immigrant women find themselves in:

- ✦ Lack of insurance or knowledge of the insurance system
- ✦ Live in an insulated community and have little information about jobs
- ✦ Women have a variety of backgrounds and abilities but are afraid to leave whatever security they have.
- ✦ Women refuse medical care or hospitalization for fear of losing a job, their income or children
- ✦ Women who have a green card are afraid to lose it and are prey to people taking of advantage of them by working more hours than is legal or are underpaid and afraid to complain.
- ✦ Women who cannot find a job because of their immigration status fall prey to men because of their vulnerability and are often kept as prisoners and withhold their green card to use the women in the sex trade including traffickers.
- ✦ In these cases, women in the sex trade, don't wear condoms when told not to for fear of losing the jobs and lives and are therefore at risk for HIV.
- ✦ Women engaged in the sex industry are afraid to be tested for HIV because of the stigma of the disease and they don't want family or neighbors to find out about the test.
- ✦ Women who have left children or other family members in their home country are despondent and or in a constant state of crisis, worried about being able to make enough to send home and because they are trying to earn money to send home for their care or to bring them, they are often prey to illegal employment.
- ✦ Women do not know who to talk to and to seek help from
- ✦ Whether women are in relationships and care about someone, or if they are working in a sex related job, fear is often the basis of decision-making. Lack of economic stability can lead to sexual exploitation
- ✦ Women are afraid of transmission and yet don't use condoms

- Women fear rejection,
- are afraid to be tested because of the fear of being positive and getting deported, even though the ban has been lifted.
- Because of cultural issues women are afraid to tell anyone about any problems they might have and create situations which could have been avoided or helped.

4B. Removing the Fear of Economic Insecurity as a Barrier

Social and economic problems within our historic, national political structure will have to undergo major structural and systemic changes before any impact will be felt on the issues faced by immigrant women including their children and family. It will take more than just working through the AIDS silo to fix the issues that include Presidential Mandates and Executive Orders, new laws and regulations and appropriations of funds at every level of government from national to rural. Immigrants must be included in the development and revision of laws and tax structures. We must start to work on an incremental basis to help women and girls before the ideal situation of services for all are implemented.

- Programs need to be created and prevention strategies need to be implemented to address socioeconomic conditions of immigrants.
- Programs need to address work requirements,
- create a safe space for women to address inequity and safety in the workplace particularly for domestic workers.

Once again, in the cases where someone in the family is incarcerated, the family must get legal, social service as well as health care to understand all of the ramifications for all family members. Those who are incarcerated and then are released must receive information about HIV/AIDS and be tested prior to being released and have test results and referrals if necessary.

5A. Stigma as a Major Barrier to the Prevention of HIV/AIDS

When dealing with HIV/AIDS, everything must be considered in the context that stigma is an omnipresent problem.

HIV is a taboo subject in communities. This prevents women from sharing their status, getting tested or asking for information for fear that her safety or information will be known by others. There is a fear of being isolated from family and children. Women have resorted to sneaking out of the house to get services and to get medical attention. Some women who have disclosed their status have been kicked out of their home and left homeless. Some have also been pushed away from their family because of fear of casual exposure. If a woman becomes sick and needs help she will not tell anyone what she has.

- ♦ Programs can play a major role in combating stigma by conducting outreach in communities with peer educators to reach out to other women to encourage them to get into care and reduce social isolation
- ♦ Leaders of all communities and within all professions and in leadership roles must be taught facts about HIV/AIDS so that they can help remove the health threatening problems related to HIV/AIDS.
- ♦ Programs must be sensitive to the fact that because of stigma and the fear of anyone recognizing them entering a testing place or caregivers location, there needs to be places set up to enable anonymous testing and care to take place in a comprehensive care situation so that HIV, substance abuse (including alcohol) and other Sexually Transmitted Diseases (STDs) would not be suspected.

6A. Housing, Children and Family Structure as Issues for Immigrant Women

- ♦ Housing is expensive, difficult to obtain and different in size, structure and location to amenities both necessary and related to enhancing quality of life.
- ♦ Housing may not lend itself to traditions where intergenerational living is common, with childcare, cooking, gardening, hunting, fishing may all have been a part of the family structure, quality of life and education.
- ♦ Inadequate housing
- ♦ Lack of Federal and local guidelines for programs as Housing Urban Development (HUD),
- ♦ Women in domestic violence situations are afraid to seek help
- ♦ Stigma and the fear of testing which could provide results which would be given or told to someone might get leaked to ICE or someone in the community or a neighbor and then the woman would lose her housing – The fear is real even if a suspected cause may not always be a reality.
- ♦ Housing may not be in climates immigrants are used to and the lack of heat may be an issue but is not complained about for fear of losing the housing.
- ♦ Housing regulations and workers in the field must develop multilingual workers with materials which combine information about the right to housing and facts about limitations regarding immigrants
- ♦ Housing groups for all populations must be funded to help PLWAs and their families – the issues should not be left to HIV/AIDS housing advocates only.

6B. Recommendations for Housing Changes for Immigrants

- Until Congress changes many of the requirements for providing entitlements to immigrants they will continue to experience hardships such as living in close quarters with other family members or strangers. Changes in the future must include HUD (Housing Urban Development) and other national and local housing programs changing guidelines and revisit definitions of family: size, income eligibility and eligibility for programs as HASA, inclusion of People Living with HIV/AIDS.
- Lack of Federal guidelines to localities with HUD programs
- Lack of accountability in areas where there are rent guidelines and immigrants often get taken advantage of.

Groups other than HIV/AIDS service groups must help by reaching out to immigrant families particularly those with a family member with HIV infection.

6C. The Development of Children and Family Structure in the US

Groups other than HIV/AIDS service groups must help by reaching out to immigrant families particularly those with a family member with HIV infection.

- Intergenerational programs and housing must be created where grandmothers, mothers and teenage daughters can meet and work on programs together.
- Programs and housing projects need to help women enjoy and celebrate their womanhood.
- Women need to be seen as gate keepers rather than caregivers
- Empower women to become leaders in their families and in their communities

Develop programs in the language of choice that includes *English as a second language teachers* as part of the group so that women become comfortable and can discuss issues of concern to them and other issues are introduced.

Immigrant women have for the most part settled in America assuming that education and health are handled by people who understand what is best for families and their children. A Parent Teacher Association (PTA) is a “foreign” entity and parents have to be introduced to participate with a critical eye not simply assuming everything is as it should be.

7A. Healthcare and Supportive Services

In this section the issues are presented with the assumption that suggestions for dealing with the problems are at all times in the language of the immigrants and if that is not possible, then a translator needs to be employed. There is an unstated assumption that the suggestions for changes in policy and practice are being made because the issues have been presented so frequently.

- It is essential that co-factors must be addressed in addition to comprehensive medical care and they are minimally: domestic violence (DV), abandonment and or trauma, mental health issues which include depression and worries about security and income, sexually transmitted diseases (STDs) and substance use including alcohol. Rape and sexual assault may become a problem in this country also.
- Women who are in dv situations living with or without their children are afraid. Women who become empowered fear more dv and cannot choose between staying or leaving a relationship – very complex issues;
- Issues of gender, including lesbians and transgendered;
- Not just HIV and women but outreach must include all facets of life because women do not respond to HIV alone.

Medical providers need to remain current on the changes and information about HIV/AIDS. This includes co-infections and manifestations of the disease that a limited English speaking person might not know how to describe. Some women are not getting the correct medical care from traditionally trained doctors who may themselves be recent immigrants doing a residency here with the same cultural reluctance as the immigrant women. Women experience a lack of education and communication with providers as well as the assumption that when they get an annual physical or visit their primary care physician that if their blood is drawn they are given an HIV test. This statement assumes someone has explained what HIV is and the assumption is made that the woman understands. It also assumes someone has explained about the need for an annual checkup. The statements are based upon the fact that very few documented women know they are entitled to certain medical care and undocumented women are not.

To insure that women who know so little about their access to care, the following recommendations are based upon the need to mutually check on the quality of care being provided – by community groups, by legal groups with an attorney or legal aide who is familiar with medical entitlements:

- Train clinicians to enable the clinicians to better recognize and look for symptoms and interconnectedness of STDs including HIV, mental health and issues of trauma and depression, particularly among people who have left a war situation, and general health care.

- ✦ Train western trained clinicians to recognize and respect a patient who may be totally unfamiliar with western medicine and knows only of their own culture. This includes a willingness and ability to be prepared to deal with other cultures;
- ✦ Co-locate primary care with mental health services, substance abuse services, GYN and pediatrics;
- ✦ Expand primary health care infrastructure to other communities;
- ✦ Develop electronic case records,
- ✦ When and if written consent forms are not used it is critical that interpreter service is present to underscore understanding and comprehension of what is being explained;
- ✦ Increase education of staff on the availability or necessity for interpretation services,
- ✦ Change policies in emergency rooms that target immigrants and inadvertently creates tension, distrust and reluctance to return.

Women who have experienced trauma regarding sex, violence, economic imprisonment who may be even 50 years are afraid to seek help and must be treated with gentle respect and not bullied to answer particularly if they do not seem to want to answer questions.

Drug and alcohol use connected with trauma issues and fleeing from their country of birth has caused some women to leave children behind.

- ✦ Incarceration of partners causes problems based on experience in their former country, by word of mouth or actually experienced by self or partner.
- ✦ Because so many women assume they will return to their home country, they maintain ties through news (print, radio or tv in their native language) so if the media does not address problems at “home” in the local programming, then the women don’t believe it is a problem at home, for example a focus on HIV.

Acculturation and too many other socio-economic problems face women here so that HIV is not on the top of the list. Many women have brought problems here as a result of rape, being victims of incest, lost children due to drug use, the acceptance of early child-bearing and leaving children behind.

8A. Faith Communities/Houses of Worship/Informal Spiritual and Cultural Traditions

Women have had experiences in their former home country either positive or negative. Faced by so many differences in this country and often not knowing whom to turn to, many immigrant women turn to what they were familiar with at home and seek to build on that relationship with the clergy here. For some women it has been a comfort, for others it has been another foreign experience with a spiritual leader trained in the US.

The cooperation of major institutions as the Catholic Archdiocese and all other religious entities including smaller spiritual and cultural traditional groups must be sought to provide access to education about the US.

Women come to houses of worship for fellowship and to find information about care for their families. When programs have attempted to offer HIV testing in houses of worship, no one will come out when it is announced. There is a resistance to:

- ✦ Increase work with church leaders
- ✦ Create and sustain effective collaborations between government, CBO's, immigrant community leaders.
- ✦ Look at the work of national organizations to identify what is working or not working. They are dealing with the immigrant populations in their country that we are trying to serve. Get their "Best Practices"
- ✦ Look and borrow from other epidemics/disease models (TB, etc)
- ✦ Trainings for clinicians to enable them to better recognize and know how to act on the symptoms and the interconnectedness of STDs, HIV, mental health, and general health specific to women. Additionally ensure that western-trained physicians are willing/able/prepared to deal with culture issues around testing, counseling and care so that it takes place.
- ✦ DV is a huge issue especially for immigrant women who react in specific ways as it is so tied to their culture, religion, etc.
- ✦ Programs that build on addressing the mistrust, fear that immigrants face when dealing with medical systems in this country.
- ✦ Get religious representatives to share their experiences working with immigrant women in New York City. Address women's immediate needs.

VI.

Additional Recommendations for Policy Change

Now where do we go, a recap and some additional recommendations for policy change:

- Economic problems within our historic national political structure will have to undergo major structural and systemic changes before the issues faced by immigrants including their children and family structure in this country, will have an impact. It will take more than working through the issue of AIDS to “fix” them. The issues mandate changes in laws, with the inclusion of immigrants thoughts and experiences in the development of the regulations and a revised tax structure. Issues with far reaching educational and fiscal implications with access to all services for immigrants can’t wait to be solved and we must begin to address the epidemic for immigrant women and girls.

The issues which must be faced and dealt with within a logical framework that helps all women, were present as issues prior to the epidemic of HIV/AIDS. They include but are not limited to women and their privacy, and reproductive rights:

Stigma and disclosure issues are real and need a sustained and well funded campaign to begin to address all women, but particularly to protect vulnerable immigrant women and girls.

- There needs to be a coordinated State and Citywide anti-stigma campaign that “speaks” to specific communities in a targeted way, in the language of choice, with multi media utilized and where women can recognize women who look like them and feel protected if they share similar experiences.
- Women who have experienced trauma regarding sex, violence, economic imprisonment who may be even 50 years are afraid to seek help.
- Rape and sexual assault may become a problem for some women in this country and may become a repetition of trauma experienced prior to arrival in the US.
- Women who are in DV situations with or without children are afraid, those who become empowered fear more DV and cannot choose between staying or leaving a relationship – very complex issues,

- ✦ Issues of gender, including lesbians and transgendered,
- ✦ Not just HIV and women but outreach must include all facets of life because rarely do women respond to HIV alone,
- ✦ Lack of trust in the government based upon socio/economic/political issues experienced in their country of origin prior to coming to the US,
- ✦ Many immigrants consider “America” as a temporary home and want to return home. Women maintain ties through news (print, radio or TV in their native language) so if they do not address problems at “home” locally, then the women don’t believe it is a problem at home, for example a focus on HIV.
- ✦ Acculturation and too many other socio-economic problems face women here so that HIV is not on the top of the list. Many women have brought problems here as a result of rape, victims of incest, lost children due to drug use, the acceptance of early child-bearing and leaving children behind,
- ✦ Drug and alcohol use connected with trauma issues and fleeing from their country of birth has caused some women to leave children behind,
- ✦ Intergenerational programs need to be created where grandmothers, mothers and daughters can meet together and work on a program,
- ✦ Programs need to encourage women to enjoy and celebrate womanhood,
- ✦ Women need to be seen as gate keepers rather than caregivers,
- ✦ Empower women to become leaders in their families and in their communities,
- ✦ Inadequate housing for our immigrant population falls within the need to change Federal-HUD guidelines and affordable housing allocations to all localities,
- ✦ Housing groups for all populations must be approached to include PLWAs in their demands for housing supplements.
- ✦ Housing regulations and workers in the field must develop multi-lingual workers and materials, combining the right to housing and legal limitations regarding immigrants.

These overarching issues require people working in the HIV/AIDS area to reach out to organizations which are already fighting on developing equity for the status of women and to seek those working to achieve an end to economic injustice, recognizing the extreme fiscal crisis faced by this country presently. While seeing an end to sexism may be long term, it is certainly something which affects the quality of life of immigrants.

- ✦ Immigrant women often arrive in the US with a lack of trust in any government on social-political issues they experienced in their country of birth.
- ✦ Legal Services for Immigrant women must be high on a list for advocates for immigrants who face too many other social-economic problems—HIV is not on top of most newcomers list.

Issues that will need (some already exist) to change are policies/laws that directly impact the epidemic and with folks working on it, something can be done.

- ✦ Delayed access to testing for women, immigrants and girls cannot be successfully changed without a push for language interpretation. Translators must be developed as a trade and source of new job training for all professions from aides to doctors in medical trade related schools. Requiring a separate consent for HIV testing may also be considered a barrier, if the doctor is not comfortable telling his patients that they need to test for HIV and other STDs. While mandated routine testing will ensure that women find out their status early and get linked to care, it is of utmost importance that because of stigma, economic constraints and cultural realities, the immigrant woman understands about HIV/AIDS and its implications.
- ✦ Change policies within the emergency room targeting immigrants, without appropriate interpretation services.
- ✦ Provide resources to providers for unfunded areas of services, such as disclosure support. This is a clinical intervention that needs a regulation from the state in order for providers to bill for it. It will increase support for women to disclose safely.

Nutrition programs and information not only need additional funds (Ryan White funding for nutrition programs is a start) but must be provided to meet the preferences of multi cultural communities to insure a healthy diet with new food products.

VII.

Advocacy

- ♦ While advocacy may not be practiced in the country of origin, we must begin to teach women how to advocate in their own and their family's behalf. Women must learn how to attend meetings, bring friends and family and speak up.
- ♦ Domestic Violence
- ♦ Immigrant women must be brought into advocacy organizations that speak for all immigrants as well as specific, in language of choice issues such as medical, educational, housing, children
- ♦ Intergenerational programs must be set up so that women feel they are within a "Safe space"
- ♦ Teach parents about what is available to help them at the local schools where their children are in attendance, such as the PTA, and parent and youth Advocacy groups.
- ♦ Voting rights
- ♦ Develop partnerships with other agencies as the Parks Department, Fire and Police that have programs immigrants and their children would benefit from.



VIII.

Conclusion

This has been a beginning effort to tie issues together that are related to women and girls and HIV/ AIDS and immigrants. We welcome you to augment this beginning discussion and to share it with all of your contacts.

A concerted long-range effort must be made to create partnerships beyond the specific issues of HIV/ AIDS. To amplify upon the progress made in starting to develop a national healthcare system, it is necessary for providers and policy makers to work together instead of continuing what we have become comfortable with in our own separate niche of expertise.

These luncheons have been an example that it is possible to bring together diverse segments of our communities and multi levels of government to discuss and make recommendations for change. Implementation plans to ensure that the impact for immigrants and women as it pertains to AIDS will depend upon many parts of each community taking the recommendations and making them work for their populations. We must face that prior to developing a national health care system, effects of racism, classism, ageism and sexism and the impracticality of implementing Brown vs Board of Education within our present housing situations kept the perpetuation of silo provision of services from providing comprehensive and equal care for all segments of our society.

The status of women has been an issue since women fought to get the vote, yet their economic status remains second class regardless of race and ethnicity. To achieve healthy women and children, and healthy families, we must take into consideration the context of our country's structure and place immigrant women within that framework. If we are to achieve a long range goal of a healthy society with equity in wages and educational status we must start in an incremental way at many entry levels. To answer each of the problems, a multi faceted approach must be developed to approach legislators, private funders and the media to reexamine the issues and situations that need both long term and immediate "fixes".



Appendix

List of Participants (March 10, 2010 and July 13, 2010)

Noilyn Abesamis-Mendoza*	Coalition for Asian American Children & Families
Philomena Alabi	Bethel of Praise Ministries
Cherly Crony	Treatment for Life
Zahaira Curiel	US Census Bureau
Holly Delany Cole	Community Resource Exchange
Joan Edwards	AIDS First
Soraya Elcock*	Consultant
Janice Emanuel Bunn	Academic Professional Consulting
Yumiko Fukuda	Asian Pacific Islander Coalition on HIV/AIDS
Lee Hildebrand	Turning Point
Henrietta Ho-Asjoe*	Center for the Study of Asian American Health
Carine Jocelyn	Diaspora
Rose Kingston	Century Dance Complex
Douglas Le	US Census Bureau
Aida Leon	Amethyst Women's Project
Esther Lok	Federation of Protestant Welfare Agencies
Michelle Lopez*	Community Health Network
Hilda Melore*	Voices of Women of Color Against AIDS
Shradha Nayan	New York Asian Women's Center
Sung Park	Intersections
Marie Pierre-Louis	Haitian Centers Council
Theresa Rodriguez	Asian Pacific Islander Coalition on HIV/AIDS
Nathaly Rubio-Torio	Voces Latinas
Luz Santiago	Wyckoff Heights Medical Center

**In attendance for both meetings*

Felicia Sarpong	Women Aglow
Claire Simon*	Young Women of Color HIV/AIDS Coalition
Suki Terada Ports*	Family Health Project
Barbara Turk	Community Resource Exchange
Lyndel Urbano	NYC Prevention Planning Group
Michael Valentin	Tibotec
Tracy L. Welsh	HIV Law Project
Irma Williams	Citiwide Harm Reduction Coalition
Xue Yi Zhen*	New York Asian Women's Center
Monica Sweeney	NYC Department of Health & Mental Hygiene Assistant Commissioner, Bureau of HIV/AIDS Prevention and Control
Andrea Barkman	NYC Department of Health & Mental Hygiene
Blayne Cutler	NYC Department of Health & Mental Hygiene
Millicent Freeman	NYC Department of Health & Mental Hygiene
Alma R. Candelas*	NYS Department of Health - AIDS Institute Director, Division of HIV Prevention
Barbara F. Agatstein	NYS Department of Health - AIDS Institute
Joan E. Edwards*	NYS Department of Health - AIDS Institute
Lilian Lee*	NYS Department of Health - AIDS Institute
Nancy Brandt*	NYS Department of Health - AIDS Institute
Johanne Morne	NYS Department of Health - AIDS Institute
Nkechi Oguagha	NYS Department of Health - AIDS Institute
Rita Aidoo*	NYS Department of Health
Sandra Estepa*	USDHHS Region II, Office on Women's Health Regional Women's Health Coordinator
Claude Marie Colimon	USDHHS Region II Office of Minority Health
Angelica Ramirez*	USDHHS Region II HIV/AIDS Regional Resource Network Program
Christopher H. Bates	USDHHS Executive Director, President's Advisory Council on HIV/AIDS Senior Health Program Advisor, Office of Public Health and Science

**In attendance for both meetings*



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