ABSTRACT

EDUCATION PROGRAMS TO PREVENT HIV/AIDS AMONG ASIAN AND PACIFIC ISLANDER OLDER ADULTS:

A GRANT PROPOSAL

By

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The purpose of this project was to locate a potential funding source and write a grant for an HIV/AIDS education programs for older Asian and Pacific Islander (API) adults. An extensive literature review was performed to investigate the need for HIV/AIDS prevention services and to expose barriers to the utilization of such services.

The proposed program will be held at AltaMed in El Monte, California, where there is a large diverse and underserved API population. The objectives include (1) increased knowledge of services, (2) increased knowledge of HIV/AIDS and the need for safe sex, and (3) empowerment to communicate about sexual matters with health care providers. By providing multilingual education programs, it is hope that the spread of HIV/AIDS will diminish among older API adults. The submission of this grant was not a requirement for the thesis project.

# EDUCATION PROGRAMS TO PREVENT HIV/AIDS AMONG ASIAN AND PACIFIC ISLANDER OLDER ADULTS: A GRANT PROPOSAL

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# CHAPTER 1

## INTRODUCTION

There has been substantial progress in medical treatment, prevention programs, and reduced stigma with respect to HIV/AIDS (human immunodeficiency virus/acquired immunodeficiency virus) over the past 33 years. With these advancements, the overall estimated number of HIV infections remained stable in every age group and in all racial/ethnic groups from 2008 to 2010 (Centers for Disease Control and Prevention [CDC], 2013c). However, the efforts to eliminate HIV/AIDS in the United States should not be reduced despite the stabilization of the number of HIV infections.

One of the groups that continue to be largely ignored in terms of sexual issues in the United States has been adults over 50 years of age (LaVail, 2010). The CDC estimated that 10.8% of the roughly 50,000 incidences of HIV infection that occur annually in the United States are among persons aged 50 years or older; among persons newly diagnosed with HIV infection in 2010, 16.5% were age 50 years or older (Brooks, Buchacz, Gebo, & Mermin, 2012). Levy-Dweck (2005) reported that older people are more susceptible to HIV infection and experience a higher risk of death due to AIDS, as they are physically less able to battle the infection and may not be tested in the first place. Early intervention and research will help contain the disease's rapid spread among the older population (Levy-Dweck, 2005).

Additionally, the CDC reported that the Asian population in the United States grew by 43% between 2000 and 2010 or more than 4 times as fast as the total United States population. Despite this significant growth, the number of Asians receiving a diagnosis of HIV has remained stable in recent years (CDC, 2014e, para. 2). However, from 2008 to 2011, Native Hawaiians and other Pacific Islanders in the United States had the third highest estimated rates of HIV diagnoses (15.3 per 100,000 people), which were lower than the rates for African Americans and Hispanics/Latinos (CDC, 2014c, para. 3).

Although HIV infection rates among Asian and Pacific Islanders (APIs) remain relatively low, there are indications of increasing trends in these populations. Using data for 2001 to 2004 from 33 states with confidential name-based HIV infection reporting for at least 4 years found that of all the racial and ethnic groups, APIs were the only ones with statistically significant percentage increases in annual HIV diagnosis rates (Adih, Hughes, Williams, Hardnett, & Campsmith, 2011).

## Statement of the Problem

The purpose of this project was to write a grant to obtain funding for an education program aimed at prevention of HIV/AIDS among API adults who ages 65 years old and older. This program would focus on educating older API adults on HIV/AIDS and other sexually transmitted infections (STIs) in order to heighten awareness, ensure a healthier sexual experience, and reduce the spread of infections. The education program would consist of one session in each desired language (for three separate sessions) every month, lasting approximately 2 hours with 10-minute breaks after every section. Participants will be able to register for classes in English or their preferred language. There would be four sections: (1) Introduction and Overview, (2) Myths and Stereotypes, (3) Facts on

HIV/AIDS, and (4) Prevention and Safety. The program would be held during the day at AltaMed in El Monte, California, through the HIV Care Services. AltaMed in El Monte serves primarily API older adults in neighboring cities such as Rosemead and Temple City. Chinese, Pilipino, and Vietnamese individuals are the majority of the API groups served and would be the targeted groups for the proposed program. However, other older APIs would be welcomed if they speak English or one of the targeted languages.

## Definitions of Terms

*Acquired Immunodeficiency Syndrome* (AIDS) is the final stage of HIV infection. It is a syndrome, rather than a single disease, since it is a complex condition with a wide range of complications and symptoms (AIDS.gov, 2014).

*Asian* is defined by the Office of Management and Budget (OMB) as describing people with origins in any part of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam (CDC, 2014e).

*Human Immunodeficiency Virus* (HIV) is a virus that weakens the immune system by destroying important cells that fight disease and infection (AIDS.gov, 2014).

*Native Hawaiian or other Pacific Islander,* as defined by the OMB, applies to people with origins in Hawaii, Guam, Samoa, or other Pacific Islands (CDC,2014c).

*Older adults* will be defined throughout this thesis project as individuals 65 years old and older.

## Relevance to Social Work and Multiculturalism

The field of social work is a profession that involves interactions with individuals of all ages, ethnicities, and socioeconomic status groups. The proposed program would

focus on older adults in the API community. The 50 and older HIV/AIDS population faces a double stigma, involving both ageism and the biases associated with HIV/AIDS (Levy-Dweck, 2005). Additionally, cultural expectations, such as fear of bringing shame to the family, family silence about sex, and the stigmatization of homosexuality and drug use in the general API community, may result in limited access to information about HIV/AIDS prevention (Adih et al., 2011). Social workers who provide services to the API community should be culturally competent regarding their customs and values.

Social workers are able to educate and provide the necessary resources for individuals who have been diagnosed with HIV/AIDS. Social workers are equipped with the distinctive skills that allow them to design a uniform assessment and intervention plan for the prevention of HIV/AIDS among the older adult population, including APIs.

# CHAPTER 2

# LITERATURE REVIEW

The literature review will first discuss the history of HIV/AIDS and how it has transformed (medically and publicly) over the years since it was first discovered in the 1980s. This will be followed with information on how this devastating disease is affecting those who are aging and not only those who are in the younger generations. It will also discuss older APIs who are affected by this disease and the barriers that restrict this population from obtaining information and services. Finally, this chapter will discuss the needs for HIV/AIDS education programs that will better inform those who are aging, focusing on those in the API population.

## Information on HIV/AIDS

### HIV

HIV is a virus that weakens the immune system by destroying important cells that fight disease and infection (AIDS.gov, 2014). It is similar to other viruses, including the flu or the common cold. However, when one is infected with HIV, the human immune system is unable to dispose of the virus; one will thus have the virus for life. HIV attacks and destroys the T-cells or CD4 cells, which are crucial in fighting infections and many diseases. Once HIV has destroyed most, if not all, CD4 cells, it can lead to the final stage of HIV infection, which is AIDS (AIDS.gov, 2014).

AIDS

AIDS is the final stage of HIV infection. It is a syndrome, rather than a single disease, since it is a complex condition with a wide range of complications and symptoms (AIDS.gov, 2014). The CDC is responsible for determining the diagnostic criteria for AIDS and has developed a list of 24 opportunistic infections associated with the determination of an AIDS diagnosis (The AIDS InfoNet.org, 2013). The normal CD4 cell count is between 500 and 1,600 per cubic millimeter of blood (cells/mm3); however, if one's CD4 cell count falls below 200 cells/mm3, it is considered that the HIV infection has progressed to AIDS (AIDS.gov, 2010). Despite having a low CD4 count, one may also be considered to have progressed to AIDS if one is HIV positive and develops one or more opportunistic illness, defined as infections that take advantage of one's weakened immune system, thus causing a devastating illness (AIDS.gov, 2010).

Transmission of HIV

Approximately 50,000 new HIV infections occur in the United States each year. HIV can be transmitted from one person to another when an HIV-infected person's body fluids (i.e., blood, semen, pre-seminal fluid, rectal fluids, vaginal fluids, and breast milk) come in contact with another person's mucous membrane or damaged tissues; it can also be directly injected into one's bloodstream through a needle or syringe (AIDS.gov, 2014). Having unprotected anal or vaginal sex, having multiple sex partners, and having other sexually transmitted infections can increase the risk of contracting HIV. Sharing needles, syringes, rinse water, or other equipment used to prepare injection drugs may also increase the risk of infection (CDC, 2014g). Some less common ways HIV may be contracted are being born to an infected mother (during pregnancy, birth, or

breastfeeding) or by receiving blood transfusions, blood products, or organ/tissue transplants that are contaminated with HIV. However, according to the CDC (2014g), this type of risk is extremely small now due to rigorous testing of the United States blood supply and donated organs and tissues.

## Thirty Years of HIV/AIDS

According to the CDC (2014a), scientists identified a type of chimpanzee in West Africa as the source of HIV infection in humans. It is believed that the chimpanzee version of the immunodeficiency virus was transmitted to humans and mutated into HIV when humans hunted these chimpanzees for meat and came into contact with their infected blood. Studies have shown that HIV may have jumped from apes to humans as far back as the late 1800s (CDC, 2014a, para. 3). It was not until June of 1981 that the CDC published a *Morbidity and Mortality Weekly Report* (*MMWR*) describing cases of a rare lung infection, pneumocystis carinii pneumonia (PCP), in five young, previously healthy gay men in Los Angeles. Each of the five men had unusual infections, indicating that his immune system was no longer working. Thus, this edition of the *MMWR* became the first official reporting of the AIDS epidemic (AIDS.gov, 2011).

Once the *San Francisco Chronicle* covered the story, doctors from across the United States overwhelmed the CDC with reports of similar cases. The CDC also received reports of rare cases of an unusually aggressive cancer, known as Kaposi's sarcoma, among a group of gay men in New York and California, leading the CDC to establish a Task Force on Kaposi's Sarcoma and Opportunistic Infections to identify risk factors and to develop a case definition for national surveillance (AIDS.gov, 2011). By

the end of the year, there was an accumulative 270 reported cases of severe immune deficiency among gay men, with 121 of those individuals deceased (AIDS.gov, 2011).

Due to the high number of deaths caused by this unimaginable epidemic, the first HIV prevention programs in the United Sates were predominantly targeted toward homosexual men and were initiated in 1982 in San Francisco, California, and New York City (Wolitski, Henny, Lyles, & Purcell, 2006). It was not until later in 1982 that the CDC used the term "AIDS" for the first time and released the first case definition of AIDS. In the following few months, the CDC reported a case of AIDS in an infant who received blood transfusions and during the week following this announcement, the *MMWR* reported 22 cases of unexplained immunodeficiency and opportunistic infections in infants (AIDS.gov, 2011). This conveyed the possibility that AIDS could be transmitted through the bloodstream.

In 1983, the CDC noted that most cases of AIDS had been reported among homosexual men with multiple partners, injection drug users, Haitians, and hemophiliacs. This suggested that AIDS was caused by an infectious agent that was transmitted sexually or through exposure to blood or blood products, which enabled the CDC to issue recommendations for preventing transmission. Two years later, the U.S. Food and Drug Administration (FDA) licensed the first commercial blood test to detect antibodies to HIV in the blood and began screening blood bank supplies throughout the country (AIDS.gov, 2011).

Fear, panic, and shock began to rise in the following years. HIV became stigmatized largely due to its association with such groups such as homosexuals and prostitutes and such behaviors as injection drug use and sex outside of marriage.

However, the layers of stigma unfortunately not only affected the person who was infected, but also branched out to those who were associated with someone who was affected by the condition, such as family members and friends (Brown, Macintyre, & Trujillo, 2003). Very little was known about HIV/AIDS other than the fact that many people worldwide were dying from this infection.

In 1985, Ryan White, a teenage boy from Indiana, contracted AIDS through contaminated blood products used to treat his hemophilia and was declined entry to his middle school. That same year, the Pentagon announced the beginning of testing all new military recruits for HIV infection and rejecting those who tested positive for the virus (AIDS.gov, 2011). Irrational fears of the already stigmatized groups fueled public concern but with no cure and no means of certain HIV identification, the number of AIDS cases rose steadily (Kobayashi, 1997).

With the high number of deaths related to AIDS, the U.S. Surgeon General, C. Everett Koop, issued the *Surgeon General's Report on AIDS* which encouraged parents and schools to have open discussions about AIDS and urged education and condom use (AIDS.gov, 2011). His report reassured the population that AIDS could not be spread casually and that public schools and facilities were safe. The report called for a nationwide education campaign that would include early sex education in schools, increased use of condoms, and voluntary testing. However, controversial issues created political and moral debates regarding AIDS. Conservatives believed that the report would corrupt schoolchildren by teaching promiscuity and some politicians called for mandatory AIDS testing of everyone. Despite all the controversy, this report on AIDS

played a crucial part in changing the public's understating of the disease (National Library of Medicine, n.d.).

The FDA approved the first antiretroviral drug, Zidovudine (AZT), in 1987. This gave hope to health care providers who had too little to offer for so long (Kobayashi, 1997). The U.S. Congress then approved $30 million in emergency funding to states for AZT, which laid the groundwork for the AIDS Drug Assistance Program that was authorized by the Ryan White Care Act in 1990. In the following months, President Reagan made his first public speech about AIDS and established a Presidential Commission on HIV, which recommended anti-bias laws to protect HIV positive people, on-demand treatment for drug addicts, and accelerated AIDS research. By the end of the year, the CDC launched the first AIDS-related public service announcement, "America Responds to AIDS" (AIDS.gov, 2011).

When HIV/AIDS first surfaced in the 1980s, the magnitude of the epidemic and the number of deaths were unimaginable (Wolitski et al., 2006, p. 597). People with AIDS increasingly became targets of stigma since press accounts and anecdotal reports from the early 1980s told frightening stories of people with AIDS, as well as those simply suspected of having the disease. People were evicted from their homes, fired from their jobs, and shunned by family and friends (Herek, 1999, p. 1106). By the end of 1989, the number of reported AIDS cases in the United States had reached 100,000 (AIDS.gov, 2011).

In the 1990s, the stigmatization of HIV/AIDS had decreased; however, people still feared those who were infected with the virus (Valdiserri, 2002, p. 341). When Ryan White passed away from an AIDS-related illness at the age of 18, the U.S. Congress

enacted the Ryan White Comprehensive AIDS Resource Emergency Act of 1990, which provided $220.5 million in federal funds for HIV community-based care and treatment services. This created a new approach for HIV prevention counseling. The CDC began a client centered approach that focused on the patient, rather than on the disease (AIDS.gov, 2011).

When Lakers basketball legend, Ervin "Magic" Johnson, Jr., announced that he had tested positive for the HIV virus and was retiring from the National Basketball Association in 1991, the world was stunned (National Basketball Association, n.d.). Mr. Johnson continues to transform public awareness through HIV/AIDS awareness and prevention programs, community empowerment centers, and the Michaels Scholarship Program (Magic Johnson Enterprises, 2014). In 1993, President Clinton established the White House Office of National AIDS Policy, which provides broad policy guidance for and leadership of the federal government's response to the AIDS epidemic (AIDS.gov, 2011). Throughout his presidential term (1993-2001) and until the time of this writing, President Clinton has been and continues to be a significant advocate for AIDS prevention.

In 1996, the number of new AIDS cases diagnosed in the United States declined for the first time since the beginning of the epidemic. AIDS was no longer the leading cause of death for all citizens ages 25 to 44, except among African Americans (AIDS.gov, 2011). In 1997, the CDC reported the first substantial decline in AIDS deaths in the United States, due largely to the use of HAART (highly active antiretroviral therapy). With the use of this new antiretroviral therapy, AIDS-related deaths in the United States declined by 47% and HAART became the new standard for HIV care

(AIDS.gov, 2011). However, the CDC (AIDS.gov, 2011) reported that African Americans accounted for 49% of the United States AIDS-related deaths, a rate that was 10 times that of Whites and 3 times that of Hispanics (AIDS.gov, 2011). This disproportionate impact of HIV/AIDS on African American communities lead to the Minority AIDS Initiative. This initiative invested in improving the nation's effectiveness in preventing and treating HIV/AIDS in African American, Hispanic, and other minority communities.

Since 2000, progress in developing prevention programs and effective treatments, as well as in reducing the stigma of HIV/AIDS, has increased significantly. However, HIV/AIDS remains a persistent problem in the United States and countries around the world. According to the CDC (2014b), about 50,000 people in the United States become infected with HIV each year. HIV/AIDS is no longer the leading cause of death for homosexual white males but it remains so for African Americans. African Americans continue to be the racial/ethnic group most affected by HIV, accounting for 44% of all new HIV infections in the year 2010. Additionally, men who have sex with men accounted for 63% of all new HIV infections, followed by 25% due to heterosexual contact and 8% due to injection drug use (CDC, 2014b).

The year 2011 marked 30 years since the start of the HIV/AIDS epidemic. With continued advancement in medical treatment, there is hope that one day there will be a cure for this dreadful virus. Prevention and testing will not lead to a cure, but treatment could.

## HIV/AIDS Prevention Programs

There is no doubt that the prevention of HIV/AIDS has improved vastly since it first emerged in 1981. Currently, the CDC supports a wide range of HIV prevention activities in the United States, including (1) collection of behavioral and HIV/AIDS case surveillance data to document trends in the epidemic and risk behaviors; (2) programs conducted by health departments at all levels, community-based and national organizations, and education-focused agencies; (3) capacity building to improve HIV prevention programs; (4) program evaluation to monitor the delivery and outcomes of prevention services; and (5) research leading to new strategies for preventing the transmission of HIV/AIDS (Wolitski et al., 2006, p. 598). With these prevention programs in place, surveillance data have shown that there has been a decrease in the yearly number of HIV incidences since 1981. In 2007, the CDC (2014b) reported 53,200 HIV infection incidences; in 2010, the number of reported HIV infection incidences decreased to 47,500.

The first HIV prevention programs focused primarily on enhancing awareness of AIDS; reducing unfounded fears about transmission; and providing basic information regarding symptoms, likely transmission routes, and risk-reduction strategies (Wolitski et al., 2006, p. 598). Today, more tools to prevent HIV are available. In addition to limiting the number of sexual partners, not sharing needles, and using condoms correctly and consistently, there are new biomedical options such as pre-exposure and post-exposure prophylaxis (CDC, 2014f). Furthermore, the CDC and its partners are pursuing a high-impact prevention approach in hope of reducing new HIV infections. This approach will use a combination of scientifically supported, cost-effective, and

expandable interventions targeted to the right populations in the right geographic areas in order to increase the impact of HIV prevention efforts. It will help maximize the impact of prevention efforts for all persons at risk for HIV infection, including gay and bisexual men; communities of color; women; injection drug users; and transgender men, women, and youth (CDC, 2013b).

## Medical-Based Prevention Efforts

For the past 30 years, there has been a vast amount of progress in medical advances in the testing and treatment of HIV/AIDS. The development and availability of the HIV antibody test in 1985 was the first big step in the history of HIV testing. This provided individuals with the ability to identify themselves as HIV positive or HIV negative (Kobayashi, 1997). In 1986, the Institute of Medicine recommended that the United States should expand the availability of serologic testing. In that same year, the CDC recommended counseling and voluntary serologic testing of asymptomatic persons in high-risk groups as a way to prevent further transmission of the virus (Valdiserri, 2011, p. 483). However, without specific antiretroviral treatments during that time, the benefits of early diagnosis of HIV infection were often challenging to recognize. As of 2014, treatment advances, especially combination antiretroviral therapy, have greatly increased the chances of long-term survival among HIV positive individuals (Valdiserri, 2011, p. 484). Furthermore, with advanced screening and medication, HIV transmission from mother to child during pregnancy, labor and delivery, or breastfeeding has decreased. Since the mid-1990s, HIV testing and preventive interventions have resulted in more than a 90% decline in the number of children perinatally infected with HIV in the United States (CDC, 2014d). Although a cure has not yet been discovered, antiretroviral therapy

can keep the virus suppressed to such low levels that infected individuals can remain healthy and are less likely to infect others (Damle, 2013).

## Public Outreach and Education

In a number of ways, HIV/AIDS prevention programs were able to inform the public regarding AIDS awareness and fears about transmission, while providing strategies to reduce risks. Some of the early CDC activities included the establishment of the National AIDS Information Line (1983), the National AIDS Clearinghouse (1987), the initiation of the nationwide America Responds to AIDS public information campaign (1987), and the distribution of *Understanding AIDS* (1988), which was a brochure that included an introduction by Surgeon General C. Everett Koop and was mailed to every residential mailing address in the United States (Wolitski et al., 2006, p. 598). During the middle to late 1980s, the CDC programs focused on high school and college-aged populations, persons at increased risk for HIV, racial and ethnic minority populations, health care workers, and those at risk for perinatal transmission. These programs increased basic knowledge about HIV transmission and prevention, reduced risky behaviors within populations at high risk for infection, and decreased negative attitudes toward persons living with HIV/AIDS (Wolitski et al., 2006, p. 598). Currently, HIV/AIDS informational material is readily accessible through local health care providers, through the Internet, by contacting the CDC, and though community-based organizations that are involved in HIV/AIDS prevention and treatment.

## New Prevention Strategies

Prevention strategies throughout the years have made substantial progress in changing the face of HIV/AIDS. There have been substantial contextual changes

between the past and present; however, there are some issues that have remained prominent over the past 30 years. In 1986, the Institute of Medicine recommended that sexual behavior and IV drug used be studied in order to find ways to reduce the risk of infection. The Institute of Medicine also recommended that the proper use of condoms should be stressed and that condoms must be widely and readily available to the public (Valdiserri, 2011, p. 482). Additionally, the 1986 publication recommended that the United States should experiment with making clean needles and syringes more freely available to reduce the sharing of contaminated equipment. Roughly, 25 years later, the national HIV/AIDS strategy continues to recognize condom availability and access to sterile needles and syringes as two scientifically supported approaches to reduce HIV transmission (Valdiserri, 2011, p. 482).

The progress in decreasing the number of HIV/AIDS cases in the United States has made a huge impact on society. The major distinction between HIV recommendations, from past to present, is greater awareness that to reduce HIV incidence at a population level, prevention approaches must be multi-modal, complementary, and mutually reinforcing (Valdiserri, 2011, p. 482). According to the CDC (2014h), the White House issued a National HIV/AIDS Strategy for the United States in 2010. This strategy has three primary goals: (1) reducing the number of people who become infected with HIV, (2) increasing access to care and improving health outcomes for people living with HIV, and (3) reducing HIV-related health disparities. This strategy reflects many of the approaches the CDC believes will make the greatest difference in reducing HIV, such as intensifying prevention programs for individuals with HIV and

those at highest risk of becoming infected with HIV, as well as targeting resources toward the interventions and areas where they will have the greatest impact.

## HIV/AIDS at Age 50 and Older

According to the CDC (2013c), the number of people aged 50 and older in the United States living with HIV infection is rising. In 2010, people aged 55 and older accounted for almost one fifth (19% or 217,000) of the estimated 1.1 million people living with HIV infection in the United States (CDC, 2013c).

Despite society's increased awareness of HIV/AIDS, some populations, such as older adults, are still largely overlooked. Levy-Dweck (2005, p. 38) studied individuals in the United States who were 50 years and older and diagnosed with HIV/AIDS and noted that between the years 1998 and 2002, the incidence of AIDS among 44 to 65 year-olds declined among Whites and Hispanics and increased among African Americans, APIs, and American Indians. Another emerging trend was that HIV/AIDS among the 50 and older population differed greatly by gender. Although Levy-Dweck's (2005, pp. 38-39) study consisted of a majority of men, the importance of recognizing women with AIDS had increased. Among persons 50 and older, 12.2% of AIDS cases were diagnosed in women, whereas this figure nearly doubled (to 21%) among women age 65 or older (Levy-Dweck, 2005, p. 39).

As one ages, it is often difficult to distinguish symptoms of HIV/AIDS from common symptoms associated with old age. Studies have shown a higher death rate from AIDS among older untreated patients as compared to their younger counterparts since many older persons are diagnosed with HIV infection late in the course of their disease, causing a late start to treatment and possibly more damage to their immune system (CDC,

2013c). Additionally, due to the effects of comorbidity in this population and the lack of AIDS-related services targeted toward their needs, the risk of infection is greater. Advocacy, annual testing, prevention and education, assessment and early intervention, collaboration with medical practitioners, greater access to treatment, and more research are needed in order to help combat rapid spread of HIV/AIDS among the older adult population (Levy-Dweck, 2005, p. 49).

## Growing Older with HIV/AIDS: New Public Health Challenges

Sexuality is one important component of well-being throughout the life span. Unfortunately, stereotypes with regard to the significance of sexuality and how it can contribute to one's well-being in later adulthood still exist (Bentrott & Margrett, 2011, p. 402). According to the CDC (2013c), many older persons are sexually active, including those who are infected with HIV. Several factors contribute to the risk of HIV infection among older adults: many older widowed and divorced people are dating again, older women are less likely to use a condom and practice safe sex since they no longer need to worry about getting pregnant, erectile dysfunction medications are readily available for older men, and physicians tend not to discuss sexual habits or drug use with older adult patients (CDC, 2013c).

Since there are gaps in knowledge about HIV/AIDS among the elderly population, Cahill and Valadéz (2013, p. e12) recommended that the CDC should fund social marketing campaigns that address the intersection of stigma related to HIV, aging, and homosexuality and target the general public, disproportionally affected communities, and health care providers. They also recommended that the content of the campaigns should promote healthy sexual lives for older adults and social acceptance of older gay

men and transgender individuals, while reinforcing the fact that heterosexuals are also at risk for HIV. Additionally, they recommended that the CDC should fund the development, tailoring, and targeting of HIV prevention interventions for older adults, including gay and bisexual men and heterosexual women. Other recommendations included the repeal of the HIV Criminalization Act, improving epidemiological surveillance systems and data collection directed toward older adults, funding national longitudinal studies that investigate how antiretroviral medications interact with aging bodies and with treatments for comorbidities, and training health care providers to be culturally competent and to assess older patients for sexual health risks and sexual behaviors (Cahill & Valadéz, 2013, p. e12).

Many health care providers fail to assess older adult patients regarding sexual health risks. This can lead to delayed treatments, poorer prognoses, and shorter HIV-to-AIDS intervals. An estimated 24% of people aged 25 to 29 who were diagnosed with HIV infection in 2010 progressed to AIDS in 12 months, compared to an estimated 44% of people aged 50 to 59, 49% of people aged 60 to 64, and 53% of people aged 65 and older (CDC, 2013c). Being able to detect the virus early and efficiently is a significant medical advancement. Life-saving medications have also transformed the HIV epidemic and increased the life expectancy of those living with HIV. However, with the increasing number of HIV positive older adults, there is a great need for senior service providers and staff of congregate living facilities to be trained in HIV and sexual orientation issues in order to provide nondiscriminatory and culturally competent care (Cahill & Valadéz, 2013, p. e13).

## Serving APIs with HIV/AIDS

Despite their significant population growth, the number of Asians receiving a diagnosis of HIV has remained stable. In 2010, the Asian population accounted for 2% (950) of the estimated 47,500 new HIV infections in the United States (CDC, 2014e). Although the numbers of cases of HIV/AIDS remain stable for this particular population, there are specific factors of concern, such as low testing rates and late testing, cultural factors, limited research, and the possibility of race/ethnicity misidentification (CDC, 2014e).

Hawaiians and other Pacific Islanders in the United States represent a small proportion of HIV infections compared to other groups due to the relatively small size of their overall population. Yet, according to the CDC (2014c), from 2008 through 2011, Hawaiians and other Pacific Islanders had the third highest rate of HIV diagnoses (15.3 per 100,000 people) in the United States. Furthermore, HIV affects Hawaiians and other Pacific Islanders in ways that are not always apparent due to their small population size and thus small sample size in most studies. As with the Asian American population, there has not been any significant change in this group in overall HIV incidences from 2008 through 2010. However, as for Asian Americans, specific issues should be taken into account, such as lack of awareness of HIV status, socioeconomic factors, cultural factors, limited research, and the possibility of race/ethnicity misidentification (CDC, 2014c).

### Cultural Issues

Racial and ethnic minorities have been disproportionately affected by HIV/AIDS since the beginning of the epidemic. There are many ethnicities within the population

labeled API, including Chinese, Filipinos, Koreans, Hawaiians, Japanese, and Vietnamese, among others, making it difficult to address the scope of HIV/AIDS problem within each group, as most systems of classification do not allow subculture identification (Sabato, 2014, p. 308). According to the CDC (2014e), more than one third of Asian Americans developed AIDS within a relatively short time after being diagnosed with HIV and 27% of Pacific Islanders were not aware of their infection. This indicated that HIV positive APIs might not be receiving adequate care and treatment in time to prevent them from developing AIDS (CDC, 2014c). Additionally, some APIs may avoid seeking testing, counseling, or treatment due to language barriers, fear of discrimination, immigration issues, and the stigma of sexuality in general and homosexuality in particular. The fear of bringing shame to the family may also interfere with HIV risk reduction strategies, such as condom use (CDC, 2014c). Some traditional Asian cultures emphasize male-dominated gender roles that empower men and deprive women of sexual negotiating power, thus increasing the rate of heterosexual HIV transmission to Asian American women.

Among APIs, AIDS diagnoses may be underreported by as much as 33% due to the misclassification of race/ethnicity in medical records, which is the main source of information on reported cases (Sabato, 2014, p. 308). Furthermore, the lack of detailed demographic information on ethnicity and place of birth makes it difficult to track differences in the AIDS epidemic among API subpopulations and to develop ethnically targeted public health measures (Sabato, 2014, p. 308). Since APIs are likely to be underrepresented in HIV/AIDS reports, policy makers in the United States have tended to focus prevention dollars on those communities of color deemed to be at the highest risk

for HIV transmission. This leaves APIs with fewer resources for information and prevention (Takahashi, Magalong, Debell, & Fasudhani, 2006, pp. 529-530).

Services for APIs

Chin, Kang, Kim, Martinez, and Eckholdt (2006) reported findings from an evaluation of the Bridges Project, a community-based intervention implemented by the API Coalition on HIV/AIDS (APICHA) to reduce disparities in care for APIs living with HIV/AIDS in New York City. Inadequate access and inconsistent utilization of care among these APIs were the focal concerns and few studies existed on their characteristics and service needs (Chin et al., 2006, pp. 910-911).

Chin et al. (2006) reported that among the API population, barriers to services were mainly due to language and cost, not knowing where to go for services, and confidentiality concerns. In order to improve the ability of HIV positive APIs to utilize existing services, the Bridges Projects reduced language and cultural barriers to existing HIV medical services though language interpretation and comprehensive case management by bilingual part-time peer workers and full-time case managers employed by APICHA (Chin et al., 2006, p. 912).

In order to provide culturally competent care, Chin et al. (2006) acknowledged the need to recognize that multiple languages and cultures exist among APIs. Their study emphasized the need for bilingual and culturally competent workers in order to serve APIs living with HIV/AIDS effectively. Over 60% of their sample, consisting of APIs who were at least 18 years old, indicated an Asian language as their primary language, indicating the need for bilingual workers and translators. In addition to language barriers, immigration status had an impact on receiving services: 55% of undocumented

participants who were in need of primary care services were able to receive them, whereas 90% of documented participants who needed such services received them (Chin et al., 2006, pp. 915-916).

According to Chin et al. (2006), providing language services is necessary for the API population but may not always be sufficient. HIV positive APIs may have limited understanding of their condition's course and treatment-related issues, regardless of language. Bilingual case manages and peer advocates may fill a critical role in clarifying and reinforcing APIs' knowledge of HIV treatment and understanding of the significance of illness markers, thus improving their compliance with antiretroviral medications (Chin et al., 2006, p. 924).

Developing and Implementing an HIV/AIDS Curriculum for Older Adults

Altschuler, Katz, and Tynan (2004) developed and implemented an HIV/AIDS prevention education curriculum targeted toward people 50 and over. Their sample of 249 participants was recruited from 14 different organizations that serve adults 50 years of age and older in California. Their curriculum addressed basic information concerning HIV/AIDS and the impact on people 50 years and older. Their results showed that (1) female participants (62%) were more likely than males (32%) to attend the education programs; (2) as age increased the likelihood of attendance decreased; and (3) those who reported a relationship with someone with HIV/AIDS, a fear of contracting HIV/AIDS, and/or a desire for updated information were found to have higher rates of participation. Additionally, participants who self-reported being moderately or very religious were found to be more likely to attend the HIV/AIDS prevention education programs compared to those who were not religious (Altschuler et al., 2004, p. 124).

Based on verbal feedback from the participants, the authors were able to identify three unique contributions of an HIV/AIDS curriculum: (1) learning that HIV/AIDS was relevant to their lives, (2) feeling empowered to speak up to their health care providers, and (3) having the opportunity to discuss an otherwise taboo topic with other people. A skillful leader who understands the multiple psychosocial needs and cultural diversity of older adults is needed in order to enhance the likelihood of success. Lastly, programs need to be sensitive to differences in group composition and cohort desires in order to address the increasing diversity of the older adult population (Altschuler et al., 2004, p. 125). Altschuler et al. (2004) also noted that targeting health care providers is needed in order for HIV/AIDS interventions to be effective for older adults.

## Conclusion

AIDS is a dreadful disease that has greatly affected the lives of many people worldwide. With a little over 30 years of continued advancements in medical testing, prevention programs, and treatment programs, there is hope that one day there will be a cure. Many researchers agree that the best way to decrease the spread of infection is through education and prevention. There is a need to push past the negative stigma toward HIV/AIDS, along with the negative stigma toward sexuality among older adults. HIV/AIDS can affect any person, regardless age, gender, race/ethnicity, or socioeconomic status. Thus, education and prevention programs designed for older adults, as well as programs that are culturally appropriate, are needed.

# CHAPTER 3

# METHODS

## Identification of Potential Funding Source

In order to locate funding for HIV/AIDS education programs for API older adults, the grant writer conducted an Internet search for possible funding sources, as well as grant funding databases. The search included potential funding sources provided by the federal, state, and local governments; HIV/AIDS foundations; foundations that provide funding for older adult educational programs; and foundations specifically focused on API populations.

The grant writer compiled a list of private agencies and foundations, as well as federal, local governmental and state agencies that were associated with HIV/AIDS. Resources included were the CDC, the County of Los Angeles Department of Health Services, the federal Ryan White Care Act, the Los Angeles County Department of Aging, and the Los Angeles County Office of AIDS Programs and Policy. Other governmental grant programs were found through grants.gov. Private agencies and foundations included in the search were the AIDS Healthcare Foundation, AIDS Partnership California, Andrus Foundation, Asian Pacific Policy and Planning Council, California AIDS Clearinghouse, California Wellness Foundation, Elton John AIDS Foundation, John A. Hartford Foundation, National AIDS Fund, and Robert Woods Johnson Foundation. Key words and phrases used to aid in identifying potential grants

included “HIV/AIDS,” “older adults,” “elderly adults,” “aging,” “adult education,” “health education,” “prevention programs,” and “Asian and Pacific Islanders.”

After examining federal, state, and local governmental websites, the grant writer was unable to locate a funding source. Many grant opportunities compiled from the list were focused on specific populations that the CDC identified as highest risk and were thus not suitable for the proposed program. The grant writer then explored the various foundation websites and was able to narrow the search down to two foundations, the California Wellness Foundation and the Archstone Foundation.

## Criteria for Selection of Actual Grant

The two remaining foundations were reviewed further to determine which would be most suitable for the proposed education program. The criteria used for the selection process included the stated purpose/mission and activities of the grant maker, funding priorities, areas of interest, geographic focus, types of support, duration of funding, and amount of funding. Additionally, a review was conducted on current and past programs/projects and dollars awarded to each type of project. The Archstone Foundation was selected based on its dedication to meeting the needs of the aging population, as well as bringing health-related services to underserved populations, its projects geared toward healthy aging, and its ability to meet the financial needs of the proposed program.

## Description of Funding Source and Submission Process

The Archstone Foundation is a private foundation that was formed in 1985 though the conversion of a non-profit health maintenance organization, then known as FHP, Inc., to a for-profit corporation. They then became a non-profit grant making organization

focused on the broad issues of health and health care delivery through the endowment resulting from the conversion agreement between the State of California and the FHP organization (Archstone, 2014a). The Archstone Foundation has become a leader in the field of aging. It has also served a key role in building the capacity of Grantmakers in Aging and in encouraging other funders to partner with them in preparing society to meet the needs of the aging population. They have operated for over two decades, have provided over 800 grants, and have awarded over $86 million (Archstone, 2014a).

The Archstone's Foundation's priorities reflect the desire to prepare society for an aging populating by focusing on aging trends, research, and program innovations. Priority is given to proposals serving the Southern California region; however, proposals from outside Southern California may be considered if they serve the state as a whole, are demonstration projects with potential for replication in California, or have a regional or national impact (Archstone, 2014b). The types of issues the Archstone Foundation considers though their Grant Making Strategy are access to care, adult day services, caregiver support, disability services, healthy aging, housing, medication management, mental health/substance abuse, professional education and training, promoting aging in the community, and transportation (Archstone, 2014c).

The Archstone Foundation accepts unsolicited letters of inquiry thought its Responsive Grant Making Strategy and on occasion will release a competitive Request for Proposals within its targeted initiative areas. Program staff review letters of inquire monthly; therefore, proposals must be submitted before the 15$^{th}$ of any given month for quick consideration (Archstone 2014d). The amount of the grant awarded varies considerably based on the size and complexity of the project. Continued funding for any

specific project is limited to a maximum of 3 years. Once a proposal is approved, the funds are issued annually in payments of 90% up front and 10% upon completion (Archstone, 2014d).

## Needs Assessment and Collection of Data for the Grant

In order for the grant writer to assess the need for education programs to prevent HIV/AIDS among older API adults, the grant writer conducted a thorough literature review. It was found that HIV/AIDS prevention programs historically focused primarily on white homosexual males, injection drug users, and the younger generation. Over the years, the focus began to shift toward African Americans and Hispanics/Latinos due to the increasing incidence of HIV/AIDS infection within those groups. However, surveillance efforts have consistently reported that the HIV/AIDS infection rate among the older adult population is on the rise. Additionally, the literature review revealed a lack of information, resources, and programs regarding HIV/AIDS targeting the older API population.

# CHAPTER 4

# PROPOSAL NARRATIVE

## Executive Summary

The purpose of this project is to implement an HIV/AIDS primary prevention program for older API adults aged 65 and older in the City of El Monte. This project will provide HIV/AIDS education to older API adults in order to raise awareness and decrease the spread of HIV/AIDS.

The development of an education program specifically focusing on this population is expected to have positive outcomes on the quality of life of older API adults. The HIV/AIDS prevention program will be provided in Chinese, Tagalog, and Vietnamese; however, other older API Adults will be welcomed if they speak English or one of the targeted languages. The goals of the HIV/AIDS prevention education program are to heighten awareness, ensure a healthier sexual experience, and reduce the spread of infection among older API adults.

## Issues to be Addressed

HIV/AIDS prevention education programs have proven its worth over the last 30 years. Since the first AIDS cases were reported in the United States in 1981, the number of cases and deaths among persons with AIDS increased rapidly during the 1980s, followed by substantial declines in new cases and deaths in the late 1990s (CDC, 2001). From 2007 to 2010, the incidence of reported HIV infections decreased from about

53,000 to about 48,000 (CDC, 2014b). The CDC's tracking of HIV/AIDS infection highlighted populations considered high-risk, thus targeting these areas with prevention strategies and prevention resources. Using a combination of scientifically proven, cost-effective, and expandable interventions targeting the right populations in geographic areas greatly increases the impact of HIV prevention efforts (CDC, 2013c).

Although HIV/AIDS can affect everyone, the hardest-hit populations currently infected include gay and bisexual men of all races and ethnicities (61% of all new HIV infections in 2009), African Americans (44% of new HIV infections in 2009), Latinos (20% of all new HIV infections in 2009), injection drug users (9% of new HIV infections in 2009), and male-to-female transgender individuals, of whom 28% tested positive for HIV (CDC, 2013c). While the number for APIs receiving a diagnosis of HIV has remained stable, the API population continues rapidly increase in the United States, increasing by 43%, or more than 4 times as fast as the total United States population between the years 2000 and 2010 (CDC, 2014e).

Several factors need to be taken into consideration regarding HIV/AIDS statistics for the API population. Factors such as lack of awareness of HIV status, language barriers, socioeconomic status, cultural factors, limited research, and the possibility of race/ethnicity misidentification (CDC, 2014c), along with the many different ethnicities classified under the API umbrella, make it difficult to address the specifics of the scope of HIV/AIDS in this population (Sabato, 2014).

The older adult population is constantly increasing, as is the number those aged 50 and older in the United States are living with HIV infection. Although there is an increase in overall awareness of HIV/AIDS, the older adult population continues to be

largely overlooked. Older adults aged 55 and older accounted for almost one fifth of the estimated 1.1 million people living with HIV infection in the United States in 2010 (CDC, 2013c). There is a blur between the symptoms of HIV/AIDS and the common symptoms associated with older age, making it difficult to diagnose and treat the infection. Negative stigma about sexuality among older adults and lack of knowledge about HIV/AIDS further increase the risk of infection.

Continued growth in the older adult API population living with HIV will ultimately lead to more new infections if prevention, care, and treatment efforts are not intensified (CDC, 2013c). Therefore, education and prevention programs catering to this diverse group of older adults are especially needed.

## Host Organization Description

The proposed program was developed in collaboration with AltaMed in El Monte, California, through its HIV Care Services. AltaMed is the sponsoring agency, which will house this program under their agency's umbrella of services provided to individuals throughout Los Angeles County. AltaMed has delivered quality care to the underserved communities of Southern California for more than 40 years and offers a wide variety of services. AltaMed serves the entire family with primary medical care, dental clinics, and complete senior long-term care services, including senior case management and the Program of All Inclusive Care for the Elderly (PACE). AltaMed also delivers disease management programs, health education, youth services, and substance abuse treatment. AltaMed is the largest independent Federally Qualified Community Health Center in the United States with more than 930,000 annual patient visits thought its 43 sites in Los Angeles and Orange Counties (AltaMed, 2014).

AltaMed's HIV Care Services has been providing quality HIV/AIDS health care to multiethnic and underserved communities for over 20 years. According to the United States Census Bureau (2014), the city of El Monte, California, had an estimate of 25.1% of Asians alone in 2010, and 0.1% of Native Hawaiian and Other Pacific Islander alone in 2010 (United States Census Bureau, 2014). Their HIV/AIDS services include prevention, counseling, treatment, specialty care, and access to clinical trials. Expert teams of highly skilled professionals in the prevention and treatment of HIV/AIDS staff AltaMed's primary care clinics. AltaMed's HIV/AIDS programs are supported by federal Ryan White Care Act dollars. Prevention services are funded by the CDC, California Department of Health Services, and Los Angeles County Office of AIDS Programs and Policy (AltaMed, 2014).

## Program Description

Participation of this program will be voluntary. Program participants will be recruited through AltaMed's senior services programs and from their HIV Care Services. Flyers will be created in English, Chinese, Tagalog, and Vietnamese and will be distributed by the facility and sent by mail to targeted groups. Transportation will also be provided for those who need it. Participants must live within 20 miles of the facility in order to use the transportation services.

The education program would consist of one session in each desired language (for four separate sessions) every month, lasting approximately 2 hours with 10-minute breaks after every section. Participants will be able to register for classes in English or their preferred language. There will be four sections: (1) Introduction and Overview, (2) Myths and Stereotypes, (3) Facts on HIV/AIDS, and (4) Prevention and Safety.

After the program, staff will remain on site to meet with any individuals who choose to speak personally with a staff member. The program staff will provide written informational brochures, as well as information about free HIV testing and treatment resources to all program participants. The education program and informational brochures will be available in English, Chinese, Tagalog, and Vietnamese. Translators for additional languages will be provided if needed.

## Objectives and Outcomes

The overall goal of the program is to raise awareness and to decrease the spread of HIV/AIDS among older API adults.

The specific objectives are:

1. Recruit 10 to 12 older API adults per education session.
2. Increase knowledge of services.
3. Increase knowledge of HIV/AIDS, as well as prevention and safety.
4. Empower participants to communicate with their health care providers.

The projected outcomes for the HIV/AIDS prevention education program for older API adults are:

1. Each session will be attended by at least 10 participants.
2. At least 85% of participants will have increased knowledge of the types of services available, as documented through pre- and posttests.
3. At least 90% of participants will increase their knowledge of HIV/AIDS, as documented by pre- and posttests. On the posttest, at least 90% will report their intention to use proper preventative measures to ensure their own safety and that of their partner.

4. On the posttest, at least 85% of participants will express confidence in their ability to communicate their questions and concerns about safe sex and related issues with their health care provider.

## Program Evaluation

The program will be evaluated utilizing several data collection methods. Attendance will be tabulated for each session. Each program participant will be given pre- and posttest surveys to assess knowledge of HIV/AIDS and services, intent to practice safe sex, and confidence levels regarding communication about such issues with their health care provider. The posttest will also participants to rate which sections of the program they found most helpful and relevant to their personal situation. Space will be provided for comments and suggestions about program content and presentation.

The pre- and posttest surveys will be developed by an HIV/AIDS specialist, modified to be appropriate for older API adults, and translated into the three targeted languages. The surveys will be reviewed by older API adults prior to their initial use.

The surveys will be distributed at the start of each session and again at the end of each session. The data collected will assist the agency in evaluating and refining the program on an ongoing basis to ensure program effectiveness.

## Sample Questions for Pre- and Posttest Surveys

1. Sexually transmitted diseases are only a young person's problem.

a. True b. False

2. HIV/AIDS is a homosexual disease. If I am heterosexual, I do not have to worry about getting it.

a. True b. False

3. Older adults should still use condoms when engaging in sexual activities.

a. True b. False

4. Regular pap smears and prostate exams test for STDs.

a. True b. False

5. If my doctor does not bring up the subject of STDs with me, then I must not be at risk.

a. True b. False

## Program Budget

See Table 1 for proposed program budget.

## Program Budget Narrative

### Personnel

Program Supervisor: This position requires an individual with a Masters in Social Work (MSW) who will be responsible for implementing all aspects of the prevention program. The person in this position will coordinate all program presentations, supervise presentation delivery and disbursement of program material, oversee collection of program evaluations and analyze data, and provide monthly program evaluation reports to the Program Director for review. This position is a 50% part-time position compensated at $45,000 per year.

HIV/AIDS Treatment Education Specialist: This position requires that the individual be certified in HIV/AIDS prevention education, with a minimum of 2 years field experience providing HIV/AIDS prevention education. The person in this position will be responsible for delivering the educational components, answering program participants' questions, providing one-on-one prevention counseling, and handing out

TABLE 1. Proposed Program Budget

| Expenses | Amount |
|---|---|
| Salaries and Benefits | |
| Program Supervisor/MSW/FTE/50% | $45,000 |
| Benefits and taxes @ 31% | $13,950 |
| HIV/AIDS Treatment Education Specialist/PTE/25% | $16,000 |
| Benefits and taxes @ 20% | $3,200 |
| HIV/AIDS Treatment Education Specialist/Bilingual/PTE/25% | $17,000 |
| Benefits and taxes @20% | $3,500 |
| TOTAL SALARIES AND BENEFITS | $98,650 |
| Direct Program Costs | |
| Translators | $1,800 |
| Program Supplies | $900 |
| Snacks for Program Participants | $4,400 |
| Office Supplies | $1,200 |
| Equipment | $3,700 |
| Telephone & Fax | $2,400 |
| Postage | $600 |
| Printing & Duplicating | $3,300 |
| Travel | $5,400 |
| TOTAL PROGRAM DIRECT COSTS | $23,700 |
| In-Kind Resources | |
| Program Director/LCSW/PTE/15% | $11,250 |
| Rent | $18,000 |
| Utilities | $600 |
| Equipment Lease | $1,200 |
| TOTAL IN-KIND RESOURCES | $31,050 |
| TOTAL PROJECT COSTS | $153,400 |
| REQUESTED COSTS | $122,350 |

prevention literature and HIV/AIDS testing and resource guides. There are two positions in this category: one is a 25% part-time effort position compensated at $16,000 per year and one is a 25% part-time effort position for a bilingual educator compensated at $17,000 per year. The bilingual educator must be fluent in one of the targeted languages.

Operations and Expenses

Translators: Approximately $150 per month will be spent on program translators who are able to speak Chinese, Tagalog, Vietnamese, and/or other API language. This will be on an as-needed basis depending on number of participants who do not speak English.

Program supplies: Approximately $75 per month will be spent on program supplies for a total of $900 per year. This will cover the cost of pens, paper, folders, chalk, and wipe-off board markers.

Snacks for program participants: Approximately $100 per week, for 44 weeks, for a total of $4,400 will be spent on snacks for program participants. This will include coffee, tea, juice, sweet breads, and fruit platters, and the necessary service utensils and condiments.

Office supplies: Approximately $100 per month for a total of $1,200 per year will be spent on office supplies. This will cover the costs of pens, pencils, paper, file folders, paper clips, tape, staples, and other necessary desk supplies for program staff.

Equipment: Equipment necessary to provide the presentations will be purchased at a total cost of $3,700 per year. This equipment includes two business notebook computers at a cost of $1,200 each, one multimedia projector at a cost of $1,000, one

freestanding projection screen at a cost of $150, and two equipment travel tote bags at a cost of $150.

Telephone and fax: Approximately $200 per month for a total of $2,400 per year will be spent on program telephone and facsimile lines.

Postage: Approximately $50 per month for a total of $600 per year will be spent on postage to mail program flyers, informational brochures, and other necessary program materials to selected program sites.

Printing and duplicating: Approximately $275 per month will be spent on printed materials for a total cost of $3,300 per year. These materials will include program flyers, HIV/AIDS prevention brochures, HIV/AIDS testing and treatment resource guides, program evaluation forms, program participation sheets, and handouts of program notes.

Travel: Approximately $450 per month for a total of $5,400 per year will be spent on travel expenses to provide mileage reimbursement for the Program Supervisor and HIV/AIDS Treatment Education Specialists to travel to and from the various program venues.

In-Kind Resources

AltaMed, El Monte, will provide office space for the program staff equivalent to $1,500 per month, plus the cost of utilities at $50 per month and the use of leased equipment, including phone equipment, facsimile machine, and two desktop computers connected to the agency's main server at costs equivalent to $100 per month. AlteMed, El Monte, is providing these resources under the HIV/AIDS program's operation budget.

Funding Requested from Archstone Foundation

The total funding requested from the Archstone Foundation for this program is $122,950 and covers necessary program personal and direct program costs.

Program Timeline

Months 01-02: Hiring of program staff, program start-up activities, such as equipment purchases, preparation of presentation and program evaluation surveys, peer review of program and evaluation materials, and pre-scheduling of prevention seminars.

Months 03-12: Continued scheduling of prevention seminars in preferred languages as well as in English. Ongoing data collection for program refinements on 4 sessions a month for approximately 44 weeks.

Month 12: Completion of program evaluation and preparation of final report on cumulative prevention program activities and outcomes.

# CHAPTER 5

# DISCUSSION

## Lessons Learned

The entire process of developing this grant project has been a valuable experience in expanding the author's knowledge and will be a useful tool in professional social work practice. The original idea for this prevention program was inspired during one of the author's previous community projects classes. Little did the author know that the inspiration of one's group project would manifest into taking it a step further, thus turning it into this grant proposal.

There were many obstacles the author overcame in order to conceive an educational prevention program designed specifically for the older API adult population. She reviewed each step of the grant writing process, from locating a host agency, to obtaining ample research, to locating a funding source, to developing a grant budget. The literature review, attending a seminar on how to develop a grant budget, and receiving assistance from a key source assisted the author immensely in completing this project.

Obtaining a sufficient amount of literature on HIV/AIDS specifically on older API adults proved to be difficult. She found that for this particular population, research was limited. Nevertheless, the research that did exist supported the need for more prevention education programs geared toward older API adults. Many different ethnicities fall under the API umbrella, which made it difficult for the author to select one

particular ethnicity upon which to focus the literature review. What proved to assist the author in obtaining literature was to utilize key words that generalized the API population rather than specifically singling out one ethnicity. Using this method produced multiple articles that assisted the author with the grant writing process.

The use of appropriate key words also helped her in locating funding opportunities from several foundations. She was able sort through an assortment of foundation, which helped her identify the source best suited for this proposed program.

## Strategies Used to Increase the Likelihood of Funding

In order to increase the likelihood for funding, the author performed a thorough review of the available literature. This process revealed evidence of the crucial need for HIV/AIDS prevention services specifically for the older adult API population. The need to overcome language barriers among older API adults was established, thus increasing the appeal of the proposed program.

She also utilized information on grant submission provided by the selected foundation. Once the author selected the foundation, she reviewed the available information about the foundation's history and mission, funding priorities, grant guidelines, frequently asked questions, and past grants including the amounts awarded. She used the information collected from the literature review and highlighted the areas that would specifically match the foundation's funding priorities and program objectives.

## Relevance to Social Work Practice

As previously stated, the field of social work is a profession that involves interactions with individuals of all ages, ethnicities, and socioeconomic status groups. Those who are 50 years and older and has HIV/AIDS are faced with a double stigma

which involves both ageism and biases that are followed with HIV/AIDS. Additionally, cultural expectations, such as fear of bringing shame to the family, family silence about sex, and the stigmatization of homosexuality and drug use in the general API community, may result in limited access to information about HIV/AIDS prevention (Adih et al., 2011). The development of this proposed program is a necessary step in addressing these myths and stereotypical attitudes, thus serving a disenfranchised group. As such, the proposed program is intertwined with social work's core values.

Social workers are able to educate and provide necessary resources for individuals who have been diagnosed with HIV/AIDS. Social workers are able to practice in a wide variety of settings at macro, mezzo, and micro levels. However, to have a major impact on the issues around them, understanding evidence-based research, knowledge of program development and budgeting, and skills in grant writing are all crucial components. It is extremely important for social work professionals to develop knowledge and competency in all areas of grant writing so that more programs can intervene with the most underserved and vulnerable populations in their communities.

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