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NEW to the UNITED STATES

Care for Foreign-Born People Living With HIV/AIDS

In the lobby sit an elderly couple, laughing and chatting in Amharic. Beside them is a mother singing a Spanish lullaby to soothe her infant daughter. A young man approaches the receptionist's desk. "Un momento, por favor," she says with a smile, picking up the ringing phone. "Unity Health Care. How may I help you?"

Beyond the waiting room at Unity Health Care's Upper Cardozo Health Center in Washington, DC, a foreign-born, new patient with HIV may be receiving an orientation on any given day. In an examination room across the hall, another patient may be receiving screening for tuberculosis (TB). Perhaps he or she came to Unity through one of the many links that the clinic has with organizations serving immigrants, such as the Ethiopian Community Development Council. Or maybe the patient was enrolled in primary care here and received HIV testing as part of the clinic's comprehensive approach to care.

Unity Health Care is a Ryan White HIV/AIDS Program grantee. It is a shining example of how grantees and providers can help foreign-born people living with HIV/AIDS (PLWHA) overcome significant barriers to HIV testing, care, and treatment. Patients here receive primary and specialty care, dental care, lab services, and case management as well as access to programs like the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). A federally funded Community Health Center, Unity has 14 sites in metropolitan Washington, D.C., that

DID YOU KNOW?

Immigrants represent about 12.6 percent of the U.S. population.¹

Prior to 2010, non-U.S. citizens with HIV were restricted from entering the country unless granted a waiver by the Department of Homeland Security. On January 4 of this year, the HIV travel ban was lifted.²

Among Hispanic immigrants, the lack of preventive screening contributes to higher rates of liver, cervical, and stomach cancers and higher mortality rates from those cancers than among native-born persons.³



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Health Resources and Services Administration

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For about 500 years, immigrants have been coming to America in search of opportunities to build a better life. They continue to come today, but along with opportunity, they sometimes encounter hardship.

One such hardship is poor access to health care. Confusing or unfamiliar health and insurance systems are cited as reasons that the longer immigrants live in the United States, indicators of poor health tend to go up, not down. Other factors, such as low-wage jobs, social vulnerability, and stigma, also contribute to bring about disproportionate rates of HIV incidence, enrollment in care with advanced disease, and needless suffering and loss.

The Ryan White HIV/AIDS Program community has long been involved in removing barriers to care for those new to America. Projects like the SPNS Border Health Initiative and many others have yielded valuable lessons in how to enroll and sustain HIV-positive immigrants in care over time. It is important to take these lessons to heart and continue to identify new ones to fulfill the promise of America that has brought so many to its shores.

Deborah Parham Hopson
HRSA Associate Administrator for HIV/AIDS

HRSA CARE Action

Publisher

U.S. Department of Health and Human Services
Health Resources and Services Administration, HIV/AIDS Bureau
5600 Fishers Lane, Room 7-05
Rockville, MD 20857
Telephone: 301.443.1993

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Cover: Mural outside Clínica Tepeyac in Denver, CO.
Page 3: HIV-positive client in Los Angeles, CA: © See Change.

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together served 81,000 people in 2008. Just 1 percent of patients had any private health insurance.

Unity's multicultural approach to serving foreign-born PLWHA mirrors that of other grantees and providers across the country. Their work is most relevant to the wider community of organizations serving these populations, because many people coming to the United States encounter a perfect storm of circumstances that fuel the spread of HIV/AIDS. The result is a disproportionate impact of HIV/AIDS among some immigrant communities. In Minnesota, for example, people born in Africa accounted for 11 percent of all newly diagnosed HIV cases in 2008 even though they made up *only 1 percent* of the State's population.⁴ Thus, the need for approaches that enroll immigrants in care and keep them there over time is on the rise.

FIRST-GENERATION IMMIGRANTS

Of the 304 million people living in the United States, 38 million are first-generation immigrants.¹ A majority are from Asia or Latin America; Mexico alone accounts for more than 30 percent of immigrants.⁵ First-generation immigrants come from a diverse array of backgrounds and regions, however—Africa, for instance, is the birthplace of well over 1 million residents of the United States.⁶

Just as their professions, cultures, and countries of origin are diverse, so too are the places immigrants settle. California, Florida, New York, and Texas are still the largest gateways for people arriving in the United States, but many States, from the Northwest to the Southeast, have seen their populations of foreign-born residents increase drastically over the past two decades.⁷ The foreign-born population of smaller metropolitan and rural areas has also risen rapidly. This population growth has had a major impact in cities and towns large and small, particularly in locales with limited social services.^{8,9}

Even with the huge diversity of the foreign-born population living in the United States, patterns emerge. For example, the question of where people settle is influenced by education level and citizenship. A recent study suggested that "com-

pared to their more urban counterparts, [rural immigrants] are more likely to be Hispanic, married, less well-educated but still skilled” as well as poor.⁹

Refugees are a special class of immigrants who are granted U.S. entry as a result of “well founded” fear and threat of persecution. Refugees are placed with local resettlement agencies by the U.S. government and receive services such as housing and food; if eligible, they are enrolled in programs like Medicaid.¹⁰

As a whole—and contrary to popular perceptions—U.S. residents not born here are younger and generally healthier than the native-born U.S. population.⁵ It may be that people leaving their country in search of work are able-bodied and prepared to cope with the stress of moving.¹¹ For immigrants, however, longer residence in the United States is correlated with increases in low birth weight infants, risk behaviors, cancer, anxiety and depression, and general mortality.¹² Longer residence is also now associated with increased prevalence of HIV: Most immigrants living with HIV disease became HIV positive after moving here.¹³ Immigrants are more likely

than native-born U.S. residents to present for care with an AIDS-defining illness.¹⁴

Foreign-born residents as a whole are less likely to seek medical or dental care than are U.S. natives and therefore miss recommended screenings and treatment for sexually transmitted infections, obesity, high blood pressure, and infectious diseases.¹⁵ The rate of TB in 2008 was 10 times higher among foreign-born populations than among native-born persons.¹⁶ Refugees—particularly those coming from war-torn countries—are at increased risk for mental illnesses such as posttraumatic stress disorder, which may be exacerbated by the stress of resettlement in an unfamiliar country.

Many people, however, do not seek treatment for physical or mental illness. One nationwide study showed that from 2000 to 2004, 74 percent of native-born U.S. residents had medical visits but just 51 percent of immigrants received care.¹⁵ This lack of access is especially devastating for foreign-born PLWHA, given how closely late entry into care is correlated with poorer health outcomes, increased morbidity, and costs of care.¹⁷

➔ “JAVIER”: A CASE STUDY



“Javier,” middle-aged and heterosexual, immigrated to the United States from Mexico when he was very young. After he graduated from high school and joined the job market, he had one experience in the late 1980s that put him at risk for HIV. In the late 1990s, he began having bouts of diarrhea, which he thought were a result of his diet. Over several months, Javier went to two different primary care physicians and a dermatologist to “cure” his symptoms. To save money, he first went to a physician in the United States referred by a friend. After no improvement, he went to a physician in Mexico, also referred by a friend. During this period, he was given many prescriptions and home remedies for his ailments, but they persisted. He was then referred to a dermatologist, who tried several prescriptions. Finally, when his body was literally shutting down, as evidenced by thrush, blisters, wasting, and a decrease in nervous system functioning, the dermatologist offered him an HIV test. It came back positive, and Javier was diagnosed with AIDS.¹⁸

SERVING FOREIGN-BORN PLWHA

The story of “Javier” (page 3) is typical of foreign-born PLWHA. The late stage of disease at which many immigrants enter care underscores the need for more thorough primary care services and greater access to HIV testing. That so many immigrants receive no primary care is, of course, a contributor to the late diagnosis of HIV among foreign-born people. But as Javier’s experience reveals, many people enrolled in medical care are not receiving appropriate screening and testing services.

“We offer testing to everyone who walks through the door,” says Luis Padilla, medical director at Unity’s Upper Cardozo Health Center. “Many of the immigrants who present with HIV here are heterosexual; many are married women,” he adds, stressing that the spread of HIV is not bound by old stereotypes and misconceptions.

Outreach services are also critical for early detection of HIV. Many such services are funded by the Centers for Disease Control and Prevention and any number of State and local initiatives. Many Ryan White HIV/AIDS Program grantees and providers receive funding from these other funders to provide services and are using creative strategies to reach HIV-positive immigrants not in care.

- ▶ *Florida’s Manatee County Rural Health Services* uses a bilingual Hispanic case manager to deliver prevention messaging and testing at community-based locations in central west Florida.
- ▶ *Florida’s Orange County Health Department* trains immigrant peer educators through the Center for HIV Education, Empowerment, Research, and Support. (This effort is known as the “CHEERS for PEERS” program.)
- ▶ *San Diego County’s San Ysidro Health Center, California* uses radio and newspaper ads to bring in people who know they are HIV positive but do not know where to go for care. Like many organizations serving Hispanics, San Ysidro Health Center uses *promotores* (bilingual health lay workers) to provide outreach in Hispanic communities and relies on bicultural staff to reach out to immigrant PLWHA and help keep them in care. “If our patients can’t relate to us, they will not come back to access care from us after receiving a positive test result,” says Rosana Scolari, director of program integration at San Ysidro Health Center.

When asked about the greatest challenge to accessing care for immigrant PLWHA, providers often answer that it is stigma. “People under the same roof won’t even know they’re HIV positive, even when they’re hospitalized,” says Keith Henry, director of HIV clinical research at the Positive Care Center at Hennepin County Medical Center, Minneapolis, Minnesota, of some African immigrant PLWHA he serves. “We’ve had patients have their stuff thrown out on the front lawn by a family member who discovered their status,” adds Karin Sabey, coordinator of the Positive Care Center’s Part C grant.

Stigma prevents PLWHA from disclosing their HIV status to families and friends and causes extreme isolation and loneliness. Without a support system, a person’s mental health and well-being can be compromised. Stigma has been documented to impede HIV testing as well as adherence to treatment.^{19,20}

The anonymity with which many clinics present their HIV/AIDS services to the community is an important component of helping PLWHA reach past stigma to seek testing and enter care. But addressing stigma is a lifelong pursuit for many immigrant PLWHA and their providers, and it permeates many aspects of care delivery. Providers report, for example, that some patients are so afraid of disclosure that they will only speak through interpreters who are positioned behind a curtain and cannot see them. To help counter this fear, some providers use Language Line, which provides anonymous over-the-phone interpretation services in 175 languages.*

Along with HIV/AIDS stigma, PLWHAs may fight other stigmas, such as those associated with mental health treatment. Mental health stigma is so strong that some providers are “debranding” mental health services. For example, at San Ysidro Health Center, counseling services are offered in a more culturally appropriate way. “We don’t call it mental health counseling,” says Scolari. “We tell clients that we have someone they can talk to, and we invite them to bring their families too.”

The effects of stigma are confounded by other fears—in particular, fear of the U.S. health care system. Many people in the United States, whether foreign or native born, are confused about the U.S. health system. For people who are foreign born, however, the U.S. health care landscape often seems especially complicated. Their expectations about how to navigate a health system may have been formed by the health care realities in their native countries. Many foreign-born PLWHA, for

*The Language Line phone number is (800) 752-6096.

instance, come from cultures that do not rely on Western medicine and are often hesitant to access it. They may have few friends and colleagues in their new country who can help them find their way in an alien system. Language and cultural barriers exacerbate the challenge.

Carolyn Hodge-Armstrong is the HIV program coordinator at DeKalb County Board of Health's Early Care Clinic in Decatur, Georgia. "We have a more complex and fragmented health care system here in the United States than many of our immigrant patients are used to," she explains. The Early Care Clinic delivers care to several Latino and Asian PLWHA, and its primary group of foreign-born patients consists of refugees from Africa. "Care is provided onsite at many of the refugee camps where our patients come from, and so they aren't used to going out to access a variety of care services that might be located in different sites here," adds Hodge-Armstrong.

Positive Care Center at Hennepin County Medical Center and other organizations serving immigrants often provide orientation services to help demystify the U.S. system and put patients on a road to better health. A Part C grantee and Part A and B subgrantee, the Positive Care Center's orientation focuses on familiarizing clients with the center's site. "The first visit is an hour and a half," says Henry, and the clients meet with a nurse and a social worker. "They get a tour of the area and see where labs are done and get plugged into social services and case management. They are even seen by our benefits counselor or sign up with other insurance during that visit." In this way, new patients at Positive Care receive an orientation to their new clinic *and* to all the services that they need to stay in care over time.

Many people new to the United States have significant financial concerns and difficulty finding employment. Many immigrants have trouble finding work even if they are trained professionals. Low-wage jobs employ a much higher proportion of foreign-born workers than native-born workers, so immigrants are more likely than their native-born counterparts to live in poverty.²¹

"They want to continue to support their families, so they wait until they are very sick to come in for care," says Richard Solero, director of infectious diseases at Florida's Orange County Health Department. Because immigrants experience poverty at high rates, meeting basic needs such as housing and, in many cases, providing for family members in their home country often take precedence over health concerns.²²

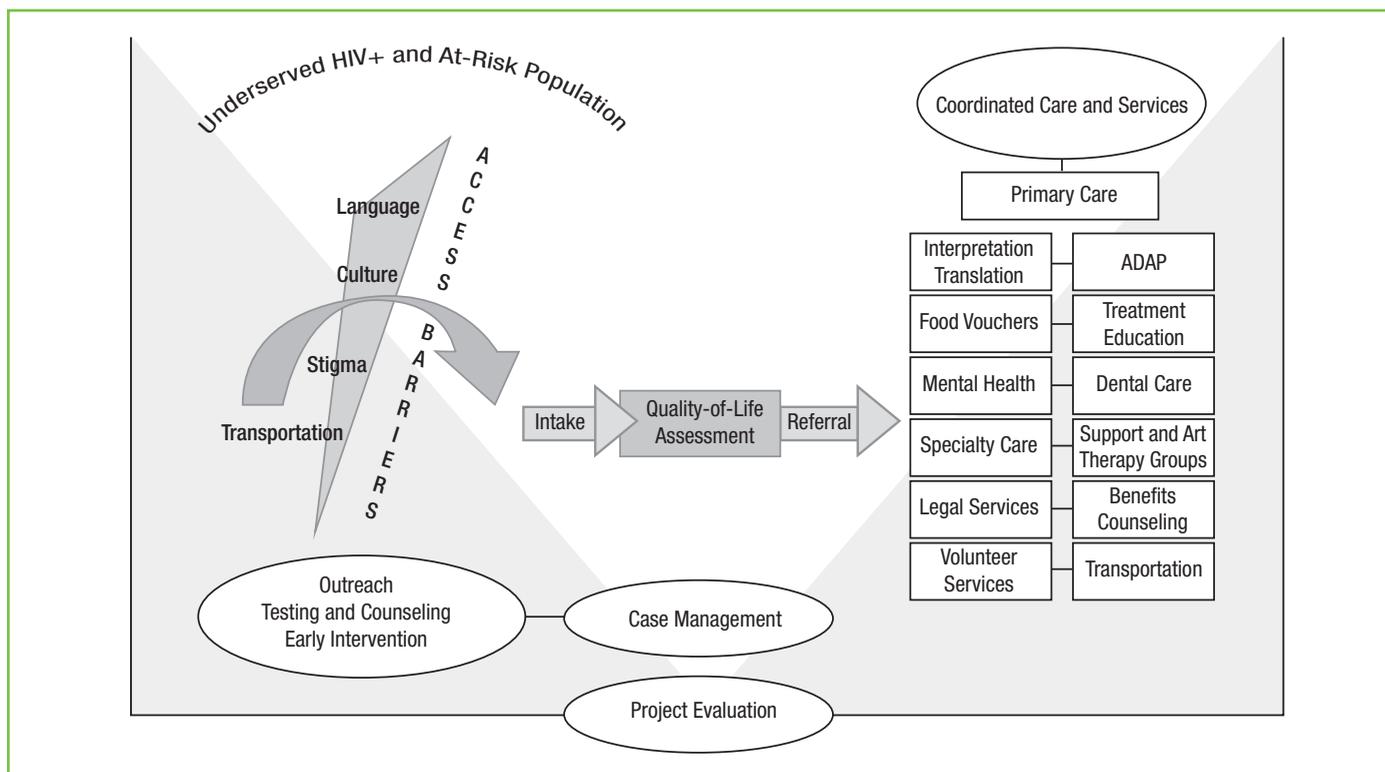
Ryan White HIV/AIDS Program grantees and providers are all too familiar with consumers' work-versus-health care battle. Low-wage workers often have no sick leave and may fear that needing to see a clinician can erode their job security or hint at their serostatus. Solero and his colleagues have intervened by offering later clinic hours 4 days a week and opening at 7:30 a.m.

LESSONS From SPNS BORDER HEALTH INITIATIVE

From 2000 to 2005, the Special Projects of National Significance (SPNS) Program carried out the U.S.–Mexico Border Health Initiative. Its purpose was to develop care models for early identification of HIV and entry to care programs on the U.S. side of the border. The study's 1,200 patients were primarily of Hispanic descent with ties to Mexico who, during the 5-year grant period, visited one of the five grantee sites funded as part of the study.

Study grantees identified many opportunities for better serving the diverse communities of PLWHA who live along the 2,000 mile U.S.–Mexico border:

- ▶ *The San Ysidro Health Center*, whose service delivery model appears on page 6, found that targeting risk behaviors rather than sexual orientation was key to successful outreach.
- ▶ *El Rio Health Center* in Tucson, Arizona, showed how clinical staff, cultural competency, and language skills can be used to improve the delivery of health services to monolingual Spanish speakers.
- ▶ In the primarily rural New Mexico border region, the *Camino de Vida Center for HIV Services* found that adding peer advocates and providing training and education for staff helped increase HIV sensitivity in the community and encouraged clients to take more control of their own health.
- ▶ The Peer advocacy component was also successful for the *Centro de Salud Familiar La Fe* in El Paso, Texas.
- ▶ *Valley AIDS Council*, also in the Texas border region, found that patients were more likely to want to see an HIV specialist in a clinic known for offering primary care to PLWHA rather than a regular internist. The study identified a "therapeutic group outcome of being among others who share a common life experience [which] tends to normalize participants' personal feelings about the disease" and may help explain why so many PLWHA choose to be around others living with HIV.¹⁸



Among the challenges faced by Mexican immigrants is how to remain engaged in HIV care when returning to Mexico for long periods of time. The U.S.–Mexico Border AIDS Education and Training Center Steering Team (UMBAST) assembled a variety of materials to help U.S. clinicians meet this challenge. The UMBAST Web site (see www.aetcborderhealth.org) contains a training curriculum and resources to assist HIV-positive clients who are returning to Mexico. The curriculum includes 53 slides with instructor talking points and bilingual one-page fact sheets for Mexico, as well as six Central American countries. (See <http://aidsetc.org/aidsetc?page=ab-01-10>.)

The many lessons of the SPNS Border Health Initiative appear in *Growing Innovative Care: Strategies for HIV/AIDS Prevention and Care Along the U.S.-Mexico Border*, available at: ftp://ftp.hrsa.gov/hab/growing_innovative_care.pdf. One major key to success was noted by every initiative grantee. A grantee described it this way:

Establishing and maintaining community collaboration and structured avenues of communication are critical to achieving successful outcomes. The process for communicating with collaborators was essential for the continued progress of [the program].¹⁸

The importance of connections and linkages is manifest far beyond the border region. “Connections are how we survive. Sharing resources with other organizations and within the medical center are part of our daily life,” says Setayehu Bedane, countywide services manager for the DeKalb County Board of Health. A simple example of how Bedane uses linkages to serve clients is the referral relationship his organization has with a refugee care clinic located just down the hall from his office.

THINGS to REMEMBER, STEPS to TAKE

A highly nuanced and specialized approach is required to reach marginalized and underserved segments of U.S. society. A one-size-fits-all approach is not appropriate because foreign-born populations come from every corner of the globe.

Diversity is the watchword both for understanding different cultures and designing programs that respond to their needs. Certain principles arising from the experience of people who work with immigrant populations can inform the important work of improving access to care and health outcomes for PLWHA who are new to this country. Those principles are summarized in the sections that follow.

Enrolling People in Care

- ▶ *HIV/AIDS stigma is endemic to many immigrant communities.* Thus, for immigrant PLWHA, it is critical to tap into the expertise of the Ryan White HIV/AIDS Program community to mitigate the effects of stigma as it relates to accessing care. The simple step of reframing HIV/AIDS-related programs in the context of primary medical care can improve access for PLWHA who are battling HIV/AIDS stigma.
- ▶ *Many people new to the United States do not regularly access primary care services in their home country and may be less likely to access care in the United States.* Providers of health care services must offer outreach within local communities or be linked with partners who do. They should also establish linkages with organizations that represent key points of entry into the medical system for underserved HIV-positive immigrants.
- ▶ *Organizations that provide outreach should do so in a manner that is both community based and culturally sensitive.* Explicit mention of HIV/AIDS, for instance, is likely to deter people from engagement given the level of stigma that is prevalent in many immigrant communities. Outreach and enrollment outcomes are often enhanced by using trained peers and workers who know a community and share a cultural background—and a language—with its members.

Staying in Care and Improving Health Outcomes

- ▶ *Comprehensive health care is essential for improving health outcomes.* Ryan White–funded grantees and providers have become experts at delivering a range of treatment and support services. This capacity is critical in serving immigrants, who suffer highly disproportionate rates of illnesses that are easily prevented and treated at the primary care level, such as TB and other respiratory infections, nutritional deficiencies, diabetes, and sexually transmitted infections. The availability of diverse services in a single location is optimal but, of course, not always feasible.
- ▶ *Demystifying the U.S. health care system is critical to help people stay in care and become involved in managing their disease.* Simple orientation programs can be helpful to patients seeking to understand a complex and confusing health care system.

- ▶ *Adapting the care approach to address cultural norms is imperative.* For example, female patients from many cultures may be uncomfortable being seen by a male practitioner or while wearing a clinical gown. Some may choose to attend appointments with husbands who speak on their behalf. In cultures where stigma of mental illness is pervasive, successful strategies include not labeling mental health services as such. For example, counseling may be framed in the context of an opportunity for a patient and his or her family to speak with someone.
- ▶ *The concept of meeting the needs of the whole person is a well-established principle for caring for PLWHA.* Successful interventions for immigrant PLWHA require linkages and relationships among a variety of health, social services, and advocacy organizations. These relationships should include refugee resettlement agencies and other immigrant-specific organizations in the community.

➔ ONLINE RESOURCES

National AIDS Education and Training Centers Cultural Competency Landing Page: www.nmaetc.org/capacity_building/cultural_competency.php

National Minority AIDS Education and Training Centers Cultural Competence Index: www.aids-ed.org/aidsetc?page=et-30-34

U.S.–Mexico Border AETC Steering Team (and to access the U.S.–Mexico HIV/AIDS Border Resources Directory): <http://aidsetc.org/aidsetc?page=ab-01-10>

HRSA CAREAction July 2006: HIV Care in the Border Regions: <http://hab.hrsa.gov/publications/July2006/>

HIV/AIDS and Immigrants: A Manual for HIV/AIDS Service Providers: www.nationalimmigrationproject.org/HIV/2004HIVManual/2004hivmanual/

HIV and U.S. Immigration: www.thebody.com/index/legal/immigration.html

Kaiser Family Foundation: Publications on Immigrant Health Care and Linguistic Access: www.kff.org/uninsured/immigrantcare_linguisticaccess.cfm

- ▶ Some barriers to care that immigrants face, such as poverty and high rates of comorbidities, are similar to those encountered by underserved people born in the United States. However, the genesis of these problems may be unique—and so may the solutions.

CONCLUSION

The SPNS Border Health Initiative and many other sources show that it is not easy for immigrants to access

HIV/AIDS care. Providers are critical to helping foreign-born PLWHA overcome barriers to care and stay in care over time. Community-based workers, targeted media, and an array of other culturally appropriate strategies can break down barriers and help increase the enrollment of immigrant PLWHA in care. In particular, a comprehensive approach to the health and essential services needs of the whole person can improve health for all underserved PLWHA—no matter where they come from.

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