

# **Evaluation Report**

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## **The Enhanced Innovative Case Management Plan *HIV/AIDS* Prevention Program**

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## Executive Summary

In 1994 the The Center for Community Health Education and Research received a grant from the U. S. Department of Health and Human Services, Health Resources and Services Administration, Special Project of National Significance to implement the Enhanced Innovative Case Management Plan (EICMP), an mv / AIDS prevention program targeted to Haitian mv consumers. In a partnership with the Boston Medical Center AIDS Clinic, the EICMP program provides Haitian mv -infected consumers education, counseling, and case management through links between CCHER and the hospital service delivery system, and between CCHER and a broad array of community-based human service providers. To ensure continuity of care, each consumer is assigned the same case manager for both hospital-based and community-based case management.

The EICMP is based on the assumption that the socio-cultural orientation of Haitians influences their perception of their susceptibility to and the severity of HIV, and the benefits of and barriers to treatment. The intervention aims to help HIV -infected individuals to understand the disease and to believe in the efficacy of treatment, resulting in increased adherence to treatment and reduced risky behavior to prevent the spread of the disease. The EICMP psychosocial intervention strategy is designed to reduce linguistic and cultural barriers by providing HIV / AIDS information, education and counseling in a culturally competent environment. The intervention is provided by Haitian professionals who share the consumer's cultural roots and speak their native language. These professionals are supportive of the Haitian culture, yet accepting of western medical practices. The objectives of the EICMP are to: (1) increase knowledge of how to prevent HIV transmission, (2) increase adherence to treatment, (3) improve utilization of health and social services, (4) increase satisfaction with CCHER case management and related services, (5) reduce risky behaviors, and (6) improve the consumer's sense of well being.

The intervention is divided into four phases. During Phases I and II, counselors obtain informed consent from consumers, explain the program, and gather baseline data about the consumer's knowledge, attitudes, and beliefs about HIV. Counselors introduce consumers to the concept of the counseling program, the purpose of multiple questionnaires and the benefits of their enrollment. During Phase III psychosocial counseling is introduced. Prior to introducing the counseling baseline data are collected on issues related to the psychosocial educational curriculum, including consumer feelings, health practices, and service utilization patterns. Data are also collected on program participant demographics and service access, service satisfaction and mental and physical health. The psychosocial educational curriculum (PEC) is then introduced to the consumer.

The PEC is a consumer -centered, flexible curriculum that includes education about the causes and transmission of HIV, treatment adherence, services available to consumers and psychosocial issues. It is administered to consumers in one-to-one interactive sessions in

Haitian Creole, with each session lasting approximately sixty minutes. The sessions include education and counseling using a non judgmental, active listening approach designed to assist the consumer in addressing the emotional, spiritual, and psychological challenges they are experiencing. The curriculum is normally completed in 8-10 sessions, but may require more sessions based on the needs of the consumer. Upon the completion of the curriculum, the instruments used to collect baseline data are administered again. The consumer then undergoes a six-month assimilation period, during which they have no contact with the counselor. After six-months, Phase IV is conducted. During Phase IV a follow-up interview is held with the consumer and a stipend is paid to the consumer for participation in the program.

Throughout the four phases of the intervention group support for HIV consumers and their families is provided. Also, each participant receives intensive and stable case management to facilitate continuity and coordination of support services. The counseling and case management staff serve as the primary advocates for the consumers in their relations with other service providers. They serve as interpreters when language is a barrier to communication between service providers and Haitian HIV consumers and as mediators in the resolution of conflicts between Haitian HIV consumers and service providers.

This evaluation assesses the process and the outcomes of the Enhanced Innovative Case Management Plan (EICMP). There are two key process evaluation questions: (1) Was the intervention implemented as planned?(2) What were the consumers' response to the intervention? There are two key outcome evaluation questions: (1) Were the goals of the intervention achieved? (2) What changes occurred in the consumers as result of the intervention? The evaluation is based on 53 participants who completed all four phases of the intervention. Case studies and in-depth interviewing methodologies were used to gather information about the implementation process. Structured surveys and in-depth interviews were used to collect outcome data. Content analysis of the counselors' case notes on 20 randomly selected consumers provided a chronology of the consumer's progression through all four phases of the intervention. In-depth interviews were held with 15 randomly selected consumers about their perceptions of the outcomes of intervention. The in-depth interviews provided an assessment of the intervention implementation from the consumer's perspective. Case notes were used to compare the intervention plan to the actual implementation to determine if the intervention was implemented as planned.

To identify changes in the consumers, in-person interviews using structured questionnaires were conducted before and after the intervention. The same structured questionnaires were administered to a comparison group of Haitian mv consumers who did not participate in the EICMP intervention. The comparison group was constructed from two programs serving Haitian HIV consumers in New York City. Each program was asked to prepare a list of its Haitian HIV consumers. The two lists were merged to construct a sampling frame, from which a stratified sample of 33 HIV consumers was selected as the comparison group. The

stratified sample was matched to the EICMP HIV consumers by age, immigration status, gender, year of HIV diagnosis, education, income, and marital status. To encourage participation a modest stipend was paid to the comparison group participants. All of the interviews were held at the comparison group service agency and conducted by the CCHER staff.

The evaluation findings indicate that overall, the EICMP intervention was implemented as planned. The findings reveal that about one third of the consumers come to CCHER as a result of an acute illness that required medical attention. However, 42 percent were referred from other CCHER programs. Many of the consumers did not have family or friends in the Boston area, or were kicked out by family when it was discovered that they are HIV infected. The services most frequently sought are housing and food services.

Features of the psycho-social educational counseling that caused the consumer to continue through completion are: (1) the consumers feel counselors are not judgmental (2) they feel that knowledge they receive helps them to understand their illness, and (3) the counselors help them with all of their needs from problems with the schools to problems with the landlord. The in-depth interviews provide clear evidence that the most important benefits from the perspective of the consumers are: (1) the sense of belonging to caring community, (2) restoration of the will to live, and (3) becoming more informed about the disease, the treatment, and how to live a successful life as a HIV- infected person. The knowledge described by the consumers as beneficial to them included: (1) terminology that explains the disease so that they understand the doctor's interpretation of the test results (e. g.. T-cell counts), (2) information about risk reduction, modes of transmission, treatment adherence and (3) information about the relationship between treatment adherence and living successfully with HIV. It is clear from the in-depth interviews that the trust relationship with the counselor is a very important component and that it is enforced by a common language and cultural understanding between the counselor and the consumer. The one-to-one counseling with the same person over time plays an important role in keeping consumers actively engaged in educational counseling.

Two other important components of the intervention are the peer educators and support group. These components enhance the effectiveness of counseling and education. The peer educators are consumers who provide support to other consumers. The peer educator plays an important social marketing role in that they are living examples for their peers to see that one can live a successful life as an HIV -infected person. They are very effective in reaching the very hard-to- reach consumers who have a fatalistic attitude about being HIV infected

The outcome evaluation findings suggest that as a result of the EICMP intervention, changes occurred in the consumers. Upon entering the program over half of the consumers had little or no knowledge of HIV. The acquisition of knowledge is reflected in the pre and post intervention measures and in the comparisons between the EICMP consumers and the

comparison group. The findings indicate that EICMP consumers are more knowledgeable about how the disease is transmitted and preventative practices and life styles than the comparison group. A higher percentage of the EICMP consumers reduced risky behaviors than the comparison group. The consumers reduced risky behavior by practicing safe sex and by changing life styles, such as eliminating or reducing alcohol consumption. Consumers reported that they are more likely to take their medication. The most frequent reasons given for not taking medication were, "don't like the side effects" and " forgot to take medication." However, keeping medical appointments was high at the onset of intervention participation, and therefore only modest changes occurred.

The EICMP consumers are using a variety of community-based health care social services. They are using more outpatient and less emergency and in-patient medical services. The need for basic services such as food and housing has decreased as EICMP consumers become more healthy and able to resume work to support themselves. The EICMP consumers are more healthy than the comparison group as indicated by the percentage of the comparison group who require in-patient medical care. Barriers to services differ for the EICMP consumers and the comparison group consumers. Language is a barrier for the comparison group, whereas transportation was reported as a barrier for the EICMP consumers. However, facilitators of service utilization were similar, both groups reported that the way the staff treats them, the usefulness of the information they receive and the convenience of appointments are major facilitators. The EICMP consumers' sense of well being increased, with the largest gains in the social and physical functioning. The EICMP consumers reported being satisfied with the CCHER services and staff.

Overall, the outcome findings reveal that consumers did benefit from participation in the EICMP program. There is an increase in knowledge about the disease. As individuals become more knowledgeable, they have more confidence in the treatment. The sense of well being is increased which also contributes to social outreach and a positive attitude about living with the disease. The major findings are that EICMP participants are less dependent on crisis health care than the comparison group and have fewer barriers to utilization of HIV medical and support services. Also, the EICMP consumers have more confidence in the efficacy of treatment they are receiving and are more empowered to take an active role in their treatment than the comparison group.

Even though the intervention was successful, the evaluation findings suggest that there is still a significant number of potential consumers outside of treatment. There is a need for a concentrated HIV education outreach campaign in the Haitian community. A general education campaign should be conducted in the Haitian community-at-large about the causes and transmission of HIV. Only through a massive educational campaign can the results obtained in this intervention spread to the larger community. The most successful outreach is likely to be conducted by the peer leaders and volunteer lay health educators.

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## Overview of the Project

### Contextual Background

*The Center for Community Health, Education and Research, Inc.* The Center for Community Health, Education and Research, Inc. (CCHER) is a community-based organization located in Dorchester, Massachusetts. Established in 1987 during the height of the AIDS epidemic within the Haitian community, the agency was originally founded as the "Haitian Community AIDS Outreach Project. In 1994 the agency was incorporated and renamed the Center for Community Health, Education, and Research, Inc. CCHER provides health care education and research to prevent the spread of disease, promote healthy lifestyles, and to improve the health status of Haitians.

In a partnership with the Boston Medical Center AIDS Clinic, CCHER provides the Enhanced Innovative Case Management Plan (EICMP) program that links services of the Boston Medical Center to the Haitian community. The EICMP program provides Haitian HIV -infected consumers education, counseling, and case management through links between CCHER and the hospital service delivery system, and between CCHER and a broad array of community-based human service providers. To ensure continuity of care, each consumer is assigned the same case manager for both hospital-based and community-based case management.

In addition to the EICMP program, CCHER provides a community health education program that trains lay health educators to provide tuberculosis, substance abuse and HIV prevention education to the Haitian community. The agency also provides a housing placement program, a home-delivery meals program, a HIV / AIDS consumer support group, and a research and information dissemination unit.

*HIV/AIDS and the Haitian Population.* The Haitian community is one of the fastest growing immigrant communities in the Greater Boston area. Most of these Haitians have encountered political repression and/or economic deprivation in their native land. As newcomers they often face the challenges of language, literacy, and cultural adaptation that are essential to socioeconomic survival in the United States. Unfortunately, Haitians are also faced with the challenge of being the only ethnic group in the United States to be singled out as an AIDS at-risk group. This stigma has caused fear and discrimination towards the Haitian community, which has exacerbated problems for Haitians who are HIV-infected, or who have AIDS.

According to the Massachusetts Department of Public Health, AIDS Surveillance Report (July 1999), there are 684 AIDS cases among Haitian residents of the Commonwealth. More than 85% of the cases have been categorized as infection through heterosexual contact. Over

60% of the AIDS cases are found in the Dorchester, Mattapan, and Hyde Park areas of Boston. The remaining of the cases are in Lynn, Chelsea, Roslindale and Brockton, Massachusetts. The high rate and rapid rise in the number of women, who represent about 40 percent of the AIDS incidents within the Haitian population, and the rise of HIV -infected children highlight the course of the HIV epidemic in the Haitian community.

Besides the complications of immigrant status, cultural barriers to health care, and fear and discrimination created by the "Haitians as AIDS carriers" hysteria, HIV -infected Haitians suffer their own intra-community stigmatization. This stigmatization often results from strong moral ideals rooted firmly in religion. Religion-based beliefs that disease is punishment for past sins and that disease is caused by immoral behaviors contribute to intra-community stigma. Also, many Haitians attribute diseases to supernatural causes. Individuals who attribute disease to supernatural powers tend to seek intervention through the voodoo priest. Others believe that diseases are sent by the gods, and therefore must be fatalistically accepted. Traditional beliefs about disease and its origin are a barrier to Haitians seeking medical attention until late in the course of an illness. Self-treatment is common and hospitals tend to be regarded as a final recourse for solving medical problems. Over time the decision to seek religious and/or supernatural remedies to health problems and to delay medical treatment as the final recourse contribute to morbidity within the community. Cultural beliefs present complex challenges for the health and social service providers involved in the care of the Haitian HIV community.

### **The Theoretical Foundations of the Intervention**

The psychosocial orientation of the EICMP represents a confluence of cultural anthropological theories of health behavior as a function of cultural orientation and social psychological theories of learning. Anthropology and social psychology theories provide a framework for understanding the interrelationship between individual behavior, the socio-cultural system and the individual's response to HIV / AIDS prevention information and education.

*Cultural Aspects of Health Behavior.* Anthropologists were among the first scientists to discover the cultural relativity of the conceptions and definitions of health and illness (Herzlich and Graham, 1973). Some of the early work of anthropologists revealed that how people define illness and health can not be separated from notions, values, and ideas about the gods, human relationships and good and evil (Rivers, 1924; Sigerist, 1955). This work led anthropologists to conclude that beliefs about the origin of the disease, individual response to the disease, and the treatment one seeks is interlinked with the culture. Thus, the representation of illness, the behavior of the sick and medical practice vary from culture to culture.

Based upon their early discoveries of the relationship between culture and health practices, anthropologists established a distinction between the conception of disease as exogenous or endogenous. In exogenous conceptions, illness is caused by the intrusion of foreign objects into the body. In endogenous conceptions, illness is caused by the magical theft of the individual's soul (Herzlich and Graham, 1973). Thus, one may believe that illness is of a magical origin caused by a evil person, or that illness is of a religious origin as a punishment for bad behavior. Whether one will seek a medical, magical, or religious treatment for the illness ---all three types of treatment, or no treatment, depends on the cultural orientation.

Evidence of the strong link between culture and health beliefs and practices are provided in anthropological studies of medical care in non- Western societies. Anthropologists report that when attempts are made to introduce western medicine into non-western cultures it is often nearly impossible to obtain acceptance of medical practices that are contrary to the culture (Mead, 1954; Gould, 1957). Anthropologists note that even when the resisting culture accepts the practices of a foreign culture, empirical studies show that medical practices inherent in the local culture intermingle with the foreign practices rather than disappear (Herzlich and Graham, 1973).

***Psychosocial Theories of Behavior.*** Psychosocial theories of behavior are rooted in social psychologic theories of learning which are taken from stimulus-response and cognitive theories that explain the behavior of individuals (Rosenstock, Strecher, and Becker, 1994). Stimulus -response theory postulates that learning results from events as reinforcements. This type of behavior does not require reasoning or thinking. Thorndike, Pavlvo, and Skinner are three of the most well known stimulus-response theorists. Cognitive theory on the other hand, postulates that subjective hypothesis or expectations held by the individual are the determinants of behavior. Cognitive theorists believe that the mental process of thinking, reasoning, hypothesizing and expecting are key components of human behavior. Lewin is one of the major contributors to the development of cognitive value-expectancy theory.

From the perspective of health behavior, cognitive learning value-expectancy theory provides the theoretical framework for explaining individual behavior. First, the individual has a desire to avoid illness or to overcome illness. Second, the individual must expect that the health action will make a difference. In other words, the individual must believe in the efficacy of the treatment to prevent, reduce, or eliminate the illness. In the case of prevention, behavior may be tempered by the individual's estimate of personal susceptibility to and severity of an illness and th~ likelihood of being able to reduce the threat through personal action (Rosenstock, Strecher, and Becker, 1994, p.6).

The EICMP is based on the assumption that the socio-cultural orientation of Haitians influences their perception of their susceptibility to and the severity of HIV, and the benefits of and ban-iers to treatment. The basic premise of the intervention is that cultural orientation affects health service utilization by the Haitian population, and through psychosocial

intervention health care practices will change over time. The intervention provides a two-part strategy: psychosocial counseling is provided to address spiritual, psychological and emotional issues. ILY education is provided to help the individual to understand the disease and to believe in the efficacy of treatment, resulting in increased adherence to treatment and reduced risky behavior to prevent the spread of the disease. To reduce language and cultural barriers to participation in the intervention, the intervention is provided in a culturally sensitive environment, by supportive professionals who speak Haitian Creole and who share the cultural roots of the Haitian consumers.

### **The Enhanced Innovative Case Management Plan**

The CCHER Enhanced Innovative Case Management Plan (EICMP) intervention consists of three components: the psychosocial counseling and education curriculum, intensive case management, and ILY -consumer support group. The model is based on the following assumptions about the relationship between cultural orientation and value-expectancy.

1. The Haitian's interpretation of health risks and the understanding of disease is derived from values and beliefs about the origins of illness rooted in the Haitian core culture.
2. For some Haitians, the health beliefs and practices of their culture of origin conflicts with health practices in the United States.
3. Haitians who do not share the health beliefs of the dominant U.S. culture and who have limited literacy in the language of the dominant culture will under utilize health care services and increase the risk of illness.
4. Therefore, due to cultural and language barriers, Haitians are less likely to adhere to western medical treatment advice, to be knowledgeable about the causes of AIDS and the transmission of HIV, to utilize health and social services and to reduce risky behaviors.

The EICMP psychosocial intervention delivery mode is designed to reduce linguistic and cultural barriers by providing ILY/AIDS information, education and counseling in a culturally competent environment. The intervention is provided by Haitians professionals who share the consumer's cultural roots and speak their native language. These professionals are supportive of the Haitian culture, yet accepting of western medical practices. The objectives of the EICMP are to: (1) increase knowledge of how to prevent ILY transmission, (2) increase adherence to treatment, (3) improve utilization of health and social services, (4) increase satisfaction with CCHER case management and related services, (5) reduce risky behaviors, and (6) improve the consumer's sense of well being.

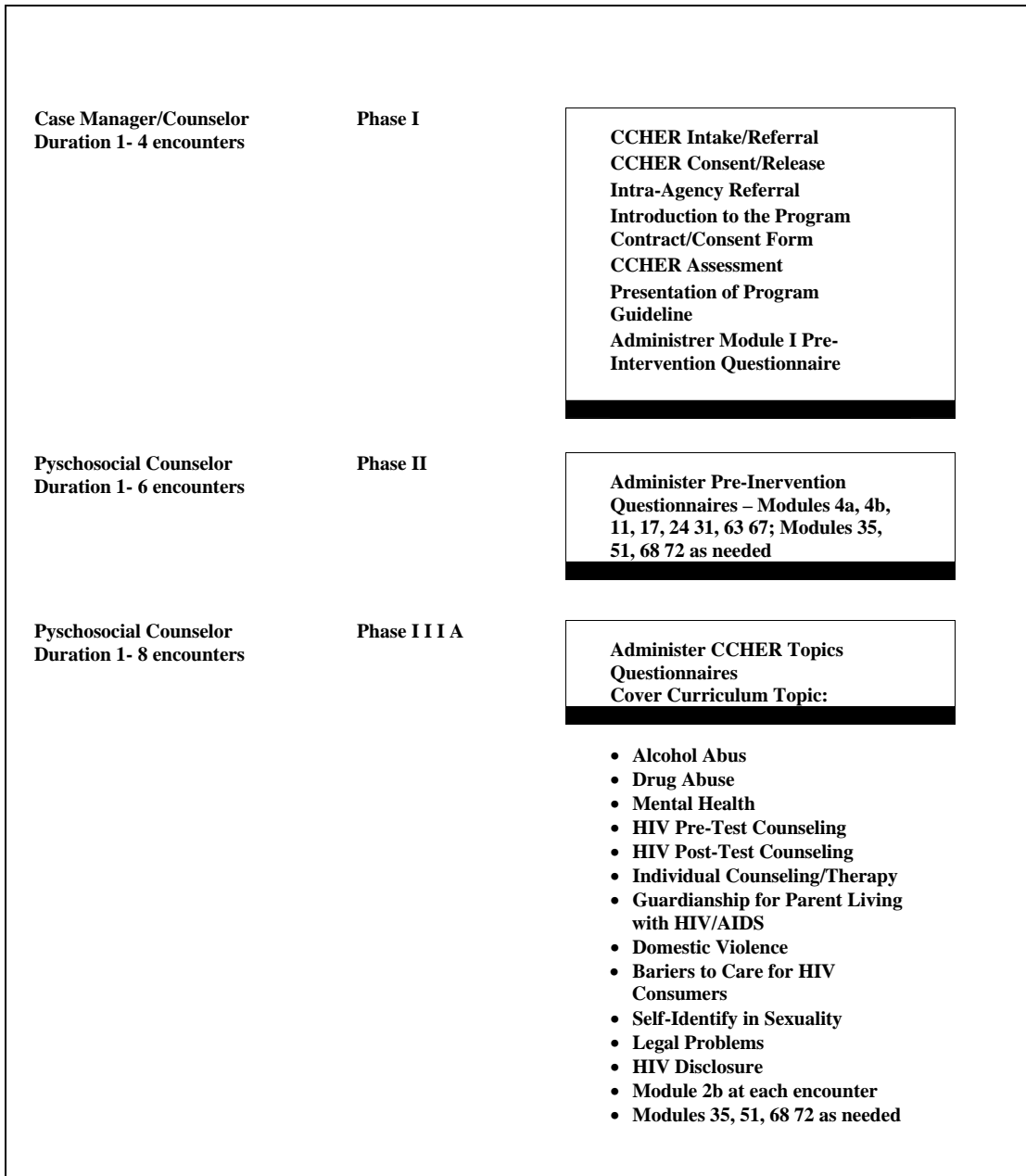
The intervention is divided into four phases presented in Diagram 1. During Phases I and **II**, counselors obtain informed consent from consumers, explain the program, and gather baseline data about the consumer's knowledge, attitudes, and beliefs about mv. Because the notion of individual counseling is itself a new concept for Haitian mv consumers, during Phases I and II counselors introduce the consumer to the concept of the counseling program, the purpose of multiple questionnaires and the benefits of their enrollment in the program

During Phase *III* psychosocial counseling is introduced. Prior to introducing the counseling, baseline data are collected on issues related to the psychosocial educational curriculum, including consumer feelings, health practices, and service utilization patterns. Data are also collected on program participant demographics and service access, service satisfaction and mental and physical health. The psychosocial educational curriculum (PEC) is then introduced to the consumer. The curriculum is provided in Appendix A. The PEC is a consumer-centered, flexible curriculum that includes education about the causes and transmission of HIV, treatment adherence, services available to consumers and psychosocial issues. It is administered to consumers in one-to-one interactive sessions in Haitian Creole, with each session lasting approximately sixty minutes. The sessions include education and counseling using a non judgmental, active listening approach designed to assist the consumer in addressing the emotional, spiritual, and psychological challenges they are experiencing. The curriculum is normally completed in 8-10 sessions, but may require more sessions based on the needs of the consumer.

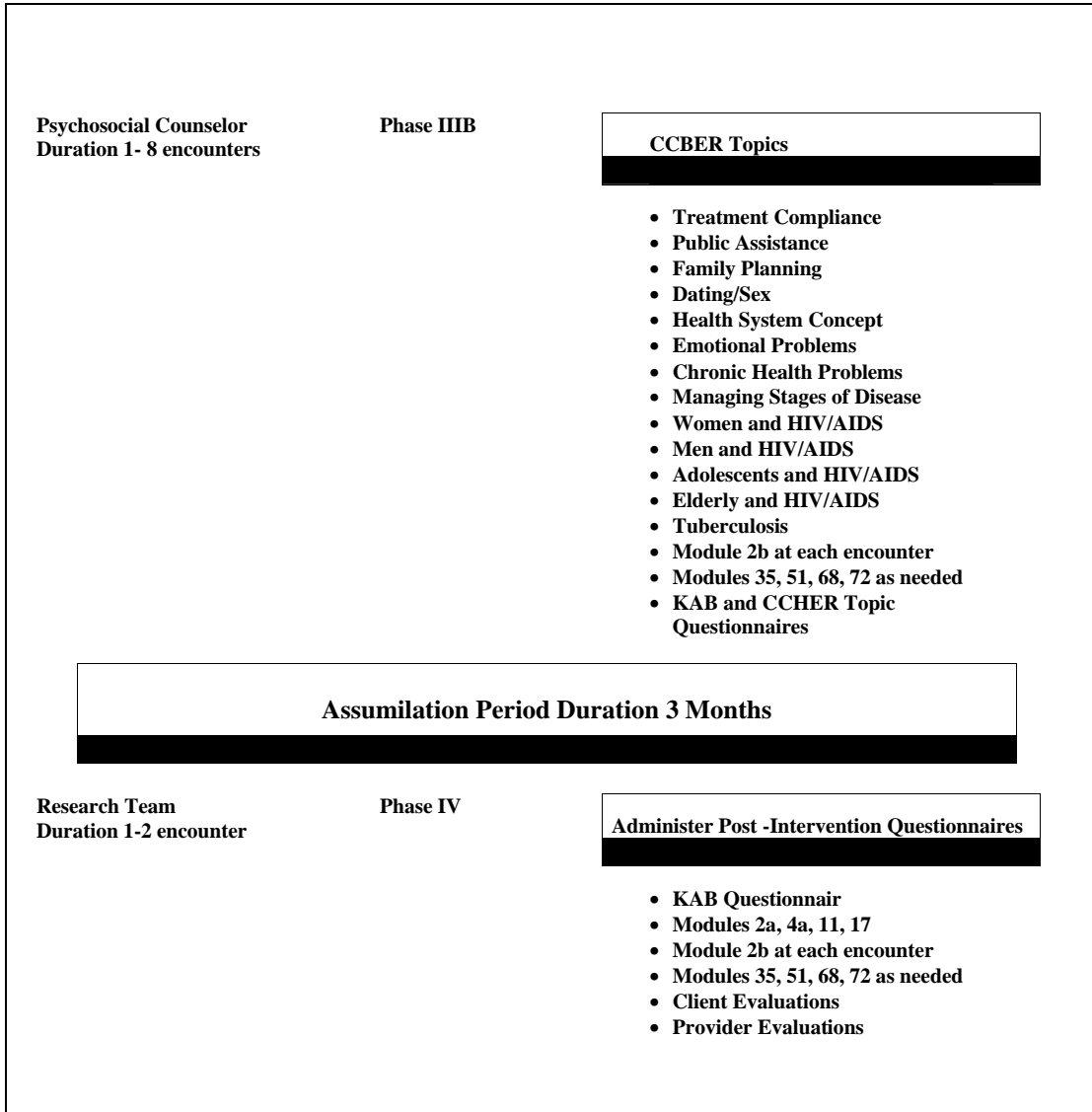
Upon the completion of the curriculum, the instruments used to collect baseline data are administered again. The consumer then undergoes a six-month assimilation period, during which they have no contact with the counselor. After six-months, Phase *IV* is conducted. During Phase *IV* a follow-up interview is held with the consumer and a stipend is paid to the consumer for participation in the program

Throughout the four phases of the intervention group support for HIV consumers and their families is provided. Also, each participant receives intensive and stable case management to facilitate continuity and coordination of support services. The counseling and case management staff serve as the primary advocates for the consumers in their relations with other service providers. They serve as interpreters when language is a barrier to communication between service providers and Haitian HIV consumers and as mediators in the resolution of conflicts between Haitian HIV consumers and service providers.

## Diagram 1 Intervention Process



Intervention Process (Continued)



## The Evaluation Design

***Evaluation Focus and Questions.*** This evaluation assesses the process and the outcomes of the Enhanced Innovative Case Management Plan (EICMP). There are two key process evaluation questions: (1) Was the intervention implemented as planned? (2) What were the consumers' responses to the intervention? There are two key outcome evaluation questions: (1) Were the goals of the intervention achieved? (2) What changes occurred in the consumers as result of the intervention?

***Sources of Information.*** Case studies and in-depth interviewing methodologies were used to gather information about the implementation process. Structured surveys and in-depth interviews were used to collect outcome data. The survey instruments and the in-depth interview questions are provided in Appendix B. Content analysis of the counselors' case notes on 20 randomly selected consumers provided a chronology of the consumer's progression through all four phases of the intervention. In-depth interviews were held with 15 randomly selected consumers about their perceptions of the outcomes of intervention. The in-depth interviews provided an assessment of the intervention implementation from the consumer's perspective. Case notes were used to compare the intervention plan to the actual implementation to determine if the intervention was implemented as planned.

To identify changes in the consumers the surveys were conducted before and after the intervention. The same structured questionnaires used in the surveys were administered to a comparison group of Haitian HIV consumers who did not participate in the EICMP intervention.

***The Comparison Group.*** The comparison group was constructed from two programs serving Haitian HIV consumers in New York City. Each program was asked to prepare a list of its Haitian HIV consumers. The two lists were merged to construct a sampling frame, from which a stratified sample of 33 *HIV* consumers was selected as the comparison group. The stratified sample was matched to CCHER HIV consumers by age, immigration status, gender, year of *HIV* diagnosis, education, income, and marital status. To encourage participation a modest stipend was paid to the comparison group participants. All of the interviews were held at the comparison group service agency and conducted by the CCHER staff.

Though similar to the CCHER HIV program, comparison programs were different. One program is operated in a multipurpose social services agency. The HIV/AIDS program, initiated by Haitian medical professionals to combat HIV/AIDS within the New York City Haitian population, serves approximately 200 HIV consumers annually. HIV/AIDS consumer services include advocacy and community education, and HIV consumer education and counseling. In addition to HIV services, the agency provides ESL and adult education programs, domestic violence counseling, and immigration services.

The other agency was originally founded to serve Haitian female HIV consumers. It currently serves approximately 220 Haitian immigrant and African American, male and female HIV consumers. The primary function of the agency is public health, with a focus on infectious diseases. In addition to adult HIV consumer services, the agency has an adolescent HIV prevention peer education program. The agency provides HIV consumers housing, pharmacy support, guardianship planning and legal assistance, and HIV education and counseling.

The comparison programs and the CCHER HIV program overlap in some of the services provided, but are different in the following ways: (1) neither program is conducted jointly with an established Medical Center, providing continuity of services between hospital-based and community-based providers, (2) neither of the comparison programs provide a cultural competency-based structured curriculum tailored to meet the Haitian HIV consumer educational needs, with a simulation and follow-up period to measure results, and (3) neither of the comparison programs provide intensive psychosocial counseling in Haitian Creole.

***Process Assessment Measures.*** The process evaluation describes (1) the characteristics of the consumers, (2) the sources of consumer referrals, the relationship between the Boston Medical Center and CCHER, (3) the key features of and consumer responses to the intervention, and (4) problems encountered, if any occurred in the implementation of the intervention. Consumer responses to the intervention include the participants' opinions and perceptions about the intervention activities such as intake (the personal nature of the questions and the length of the interview), counseling services, support group, etc.

***Outcome Assessment Measures.*** The outcome measures included the *consumers' subjective assessment of the results of the intervention and objective measures of the attainment of the predetermined outcomes. The consumers' subjective assessments of the intervention were based on the semi-structured in-depth interviews.* Predetermined intervention *outcome effectiveness measures* include, (1) increased knowledge of how to prevent HIV transmission, (2) increased adherence to treatment, (3) improved utilization of health and social services, (4) increased satisfaction with CCHER case management and related services, (5) reduced risky behaviors, and (6) improved consumer sense of well being. *Measures of increased knowledge of HIV* included knowledge of how HIV is transmitted, how to reduce the risk of contracting HIV, available drug treatment of HIV, and knowledge of drug adherence requirements. *Improved adherence to treatment* included adherence to medication regimens, and decrease in missed appointments to health care providers. *Increased utilization of health and social services* included the use of HIV prevention services, in- and out-patient HIV health care services, substance abuse services, and case management services. *Increase in consumer satisfaction* included satisfaction with the overall service quality, the quality of information provided by staff, the responsiveness of staff to consumer needs, staff respect for consumers, staff availability to help consumers.

*Change in risky behavior* included to cease or to decrease the frequency of unprotected sex, decrease in the number of persons with whom the individual has had unprotected sex, and cease or decrease in unsafe injected substance abuse. *Sense of well being* included the ability to handle problems, the ability to get along with people, sense of being loved, happiness with work, and general satisfaction with standard of living. Pre and post intervention data were gathered to determine the degree of goal attainment. Comparisons were made of the EICMP consumers before and after the intervention and between the EICMP consumers and the comparison group of non-EICMP consumers after the intervention.

### **Process Evaluation Findings**

Over a three-year period CCHER has implemented the Enhanced Innovative Case Management Plan by providing continuous care to *HIV* consumers. A total of 120 -150 referrals were made to CCHER; 70 enrolled in the EICMP and 53 of the consumers completed all phases of the plan. Five individuals enrolled in counseling and later decided not to participate. Five consumers received all of the intervention phases, but did not complete the follow-up interview after the simulation period. Six consumers enrolled in the EICMP and did not receive the intervention. Thirty of the 53 who completed all phases of the program are participating in the CCHER HIV / AIDS support group, 18 are either working as a peer educator or as a volunteer in other CCHER programs.

The data show that about half the potential client population participated in the intervention. Since no data were collected on the non-enrollees, the reasons for their declining services through the EICMP are unknown. The CCHER staff speculates that the non-enrollees are individuals who have strong fears of the social consequences of others finding out that they have HIV. The social penalty of being rejected by love ones and shunned by the community is threatening to some Haitians. However, without non-enrollee data it is uncertain as to their reasons for not participating in the intervention. Data on non-participants could have provided some insight into how to plan strategies for outreach and for educating the Haitian community about HIV.

### **Key Features of the Intervention**

The key features of the EICMP intervention are (1) continuity of care provided by assigning the same case managers to provided case management services at the hospital site and in the community, (2) integration of EICMP with community-based service providers to meet the total physical, mental, and spiritual needs of the *HIV* consumer, and (3) the use of bilingual/bicultural staff who serve as the interpreters and cultural brokers for Haitian *HIV* consumers. Case managers are jointly placed at the hospital and in the CCHER community-based office and serve as the liaisons to a network of service providers in the community. This network includes private physicians and neighborhood health centers, housing, legal, employment and an array of other social service providers.

The case managers are the critical link to delivery of HIV consumer services. In addition to being the major broker for services from other providers, the case managers are also the link to in-house services provided by CCHER such as the substance abuse program, the housing program, support groups, and home-delivered meals. All of the case managers are Haitian and speak Haitian Creole. They are trained in the fields of public health, social work, and mental health counseling. They bring professional expertise and a cultural orientation to serving the consumer population.

A psychosocial educational counseling curriculum of 25 topics was administered by psychosocial counselors. The curriculum is a psychosocial educational counseling model that is based on nonjudgmental, active listening and unconditional belief in the ability of the consumers to take charge of the events that affect their lives. With the assistance of the Boston University School of Social Work, two culturally appropriate research instruments were designed to capture the consumers' knowledge, attitudes, and beliefs about HIV. A topical questionnaire to assess consumer feelings, health practices and service utilization patterns was also developed. The intake and assessment information allowed counselors to assess consumer's needs prior to administering the counseling curriculum.

Table 1

EICMP Enrollee Site Preferences for Intervention

<b>Intervention Location</b>	<b>Frequency (N=70)</b>
Received the entire intervention through in-home visitations	10
Came to CCHER for the entire intervention	13
Started the intervention at home and switched to making visits to the CCHER office	9
Started the intervention at CCHER and later requested in-home visits	3
Started intervention via telephone and switched to making visits to the CCHER office	14
Started the intervention in the hospital and began coming to the office later	10

Consumers who enroll in the EICMP have the option of receiving the intervention through in-home visits, by telephone, or at the CCHER office. The rationale is to provide the intervention in the most comfortable environment for the consumer. Consumer counseling in the privacy of the home allows consumers time to work through their anxieties without the fear of exposure. Data presented in Table 1 indicate that over half of the consumers selected telephone or in-home visits. Fourteen percent of the consumers received all of the intervention through in-home visits and nineteen percent received all of the intervention at the CCHER office. Twenty percent of the consumers started the intervention at home and later began coming to the CCHER office.

The data presented in Table 1 indicate that 71 percent of the consumers who began counseling in a private setting later switched to coming to the office for counseling and education. These data suggest, (1) the option of receiving counseling in the privacy of their home or by telephone was the determining factor in enrolling for counseling, and (2) as the counseling and education progressed the individual became less inhibited and more open to learning about the disease. Giving the consumer time to adjust to knowing that they are HIV infected and to work through their psychosocial issues allowed the individual to determine when they were ready to take the next step in the process of living with the virus.

Table 2

General Characteristics of EICMP Emollee

Category	Percentage Distribution (N=70)
Country of Origin	100.00
Haiti	
Primary L. Inguage	
Haitian Creole	70.00
English and Creole	17.00
Other	13.00
Gender	
Female	39.00
Male	31.00
Age	
13-19	1.43
20-29	7.14
30-39	44.29
40-49	40.00
50+	7.14
Marital Status	
Common uw	7.14
Divorced	11.43
Married	28.57
Separated	12.86
Single	24.29
Widowed	15.71
Employment Status	
Disabled	27.14
Full-time	7.14
Part-time	14.29
Unemployed	50.00
Other	1.43

(Table 2 continued)

<b>Category</b>	<b>Percentage Distribution (N=70)</b>
<b>Primary Source of Income</b>	
Social Security	2.86
SSI	32.86
State Disability	2.86
AFDC	5.76
Wages	21.43
No Income	32.86
<b>Income Last Month</b>	
1-500	29.17
501-1,000	33.30
1,001 -1,500	4.17
1,501 -2,000	4.17
No Income	29.17
<b>Education</b>	
Elementary	25.00
<sup>1</sup> Secondary	71.87
College	3.10
<b>Religion</b>	
Catholic	47.00
Protestant	44.00
Vodun	6.00
Other	3.00
<b>Living Arrangement</b>	
Has own place of dwelling	57.14
Lives in other persons's home	28.57
<sup>2</sup> Lives in an institution	7.15
<sup>3</sup> Homeless	1.43
<b>Partner HIV Status</b>	
Don't know	52.40
Negative	9.50
Positive	38.10
<b>Place of Residence</b>	
Dorchester/Roxbury	56.60
Mattapan/Hyde Park	20.75
Jamacia Plain	9.43
Other	13.22

<sup>1</sup> Four years of secondary school is comparable to two years of college in the United States. Therefore, these consumers have not completed the four years, but have completed an education equivalent to high school in the United States.

<sup>2</sup> Institution is defined as group homes for HN / Aills consumers, personal care, and medically assisted shelter homes that provide clinical and social support services

<sup>3</sup> Homeless refers to those individuals who were homeless at the time they began Phase I of the intervention.

***Characteristics of Consumers***

Over the period of 3 years, CCHER provided services to seventy EICMP HIV consumers. Table 2 shows that all of the consumers are Haitian born. Fifty-seven percent of the consumers reside in the Dorchester/Roxbury communities; 21 percent in Mattapan/Hyde Park communities, 9 percent in Jamacia Plain and 13 percent reside in other communities throughout the Massachusetts Bay Area. Fifty-nine percent of the consumers are female and 41 percent is male; and 84 percent is between ages of 30 and 49. Thirty-six percent of the consumers are married and living with the spouse; 13 percent is separated; 16 percent is widowed; 11 percent is divorced and 24 percent is single. Of the widowed consumers, 99 percent of the deceased spouses died of AIDS. Haitian Creole is the primary language of 64 percent of the consumers; 72 percent has more than grammar school education; 25 percent completed grade school; and 3 percent has a college education. Forty-seven percent of the consumers report that they are Catholic; 44 percent, Protestant; 6 percent, Vodun and 2 percent reported other.

Eight-seven percent of the consumers live with family. Ninety-nine percent of the consumers have housing and only 1 percent was homeless at the time they enrolled in the EICMP. Although only 1 percent of the consumers reported being homeless in the counseling intake interview, one-third were homeless at the time they began case management. The explanation for this disparity is that one of the goals of case management is to stabilize the individual before beginning counseling and education. Housing is provided as one of the requirements to stabilize the consumer. Therefore, by the time the consumer enrolled in counseling they were no longer homeless.

Table 3

EICMP Enrollee Primary Health Care Providers

<b>Distribution (N=70)</b>	<b>Percentage</b>
Provider	
HMO	1.43
Hospital Based Outpatient Clinic	90.00
Publicly funded Community Health Clinic	4.29
None	2.86
Health Care Source of Pay	
Private Insurance	7.14
Medicaid or Other Public Pay	50.00
Medicaid Managed Care	14.29
Self-Pay	4.29
No payer Insurance	17.14

Fifty percent of the consumers reported that they were unemployed; 27 percent, disabled; and 21 percent work part or full time. The primary source of income for 33 percent of the consumers is Supplemental Security Income; 33 percent has no income; 21 percent reported

wages as the primary source of income; and 10 percent receives AFDC. Table 3 shows that 64 percent of the consumers' medical care is pay by Medicaid; 17 percent have no payer; 4 percent payout-of -pocket for their medical care; and 7 percent have private insurance.

### Implementation of the Intervention

**Consumer Referrals.** Data presented in Table 4 reveal that the two most frequent sources of referrals to the EICMP program are from other CCHER programs, 42 percent; the Boston Medical Center HIV clinic, 30 percent; CCHER consumers provide 8 percent; and other health and human service organizations serving the Haitian community provide 10 percent of the referrals. Twenty-three percent of the referrals are made due to a new HIV positive diagnosis. Table 5 reveals that the reasons for the medical visit resulting in a positive HIV diagnosis include not feeling well, 47 percent; routine medical check-up, 20 percent; knowledge of exposure to HIV, 3 percent; immigration medical requirement, 6 percent; presumed to be at-risk, 22 percent; and other 3 percent.

The data presented in Table 6 indicate that 67 percent of the consumers reported contacting the HIV virus through heterosexual sex; 4 percent through sex with a same sex partner; 3 percent from blood transfusion and 23 percent did not know how they contacted the virus. Four percent of the consumers felt the virus was sent by a curse from a supernatural power. Table 2 shows that 38 percent of the consumers' partners have tested HIV positive; 10 percent have partners who have tested negative; and 52 percent do not know if their partners have been tested.

Table 4

#### Sources of and Reasons for EICMP Emollée Referrals to CCHER

Source of Referral	Percentage Distribution (N=70)
BMC	30.00
Other CCHER Program	42.00
Relative or Friend	8.00
Other Social Service Provider	10.00
Other	10.00
Reasons for Referral	
HIV+ Diagnosis	23.40
Housing	3.10
Meal Program/Groceries	3.10
Social Services Case Management	15.60
Mental Health Counseling	54.80

Table 5

EICMP Emollee Reason for Medical Visit Leading to HIV Diagnosis

Reason	Percentage Distribution (N=70)
Felt Sick	46.40
Immigration health requirement	5.80
Routine Medical Check Up	20.30
Presumed Risk	24.60
Known Risk	2.90

Table 6

EICMP Emollee Identification of Source of HIV Transmission

Source	Percentage Distribution (N=70)
Unprotected sexual contact with same sex partner	3.79
Unprotected sexual contact with opposite sex partner	67.08
Blood products through transfusion	2.53
Curse sent by supernatural power	3.79
Don't know	22.78

***Consumer Response to the Intervention.*** The counseling and education intervention process begins with intake and assessment. During Phases I and II counselors obtain informed consent from consumers, explain the program, and gather baseline data about the consumer's knowledge, attitudes, and beliefs about *HIV*. Consumers receive a \$25 stipend upon completion of Phase II. The data collection is very lengthy and is conducted in 2 to 3 sessions. The consumers answered a battery of very personal questions about their personal life, such as sexual practices and drug use. The survey data reveal that most consumers replied no to all of the sensitive questions about drug use. Therefore it is difficult to determine the degree to which substance abuse is a risk factor within this population.

Qualitative data from the in-depth interviews reveal that the consumers did not feel the length of the intake and assessment interviews were too long. Nor did the consumers feel that the interview content was an invasion of privacy. Most had already been through a battery of questions with the medical personnel at the hospital and had grown accustomed to the process. These consumers' statements reflect the majority of the consumers' feelings about the intake process:

"I had started already, I had been in another group which asked me the same questions. When you do something for the second time you are used to it. The first time I was a little embarrassed but the second time I was used to it."

Another response was to accept the process as a part of getting help:

"I thought it was quite normal for them to ask me all those questions because if they don't ask you questions they can't know what you have inside you. And the questions themselves helped me to understand things (the program) more."

During Phase III, curriculum topics are administered in the Haitian Creole language. The first step in the counseling process is to help clients to cope with their illness and to begin living with the virus. Consumers were provided education to help them understand how the virus is acquired and how to prevent transmitting it to others. The long-term goals of counseling and education are to prepare the consumer to successfully live with the virus and to accept the responsibility for preventing the transmission of the disease.

The length of time a person spends in individual counseling varies according to their psychological and emotional state and their response to counseling. The range of sessions required to complete the curriculum was from 8 to 49 with an average of 16.5 sessions. The average exceeds 10, which was the projected number of sessions to complete the curriculum. A justification for this variance is provided in the cases analyses, which reveal that during the initial stages of the intervention 85 percent of the consumers were emotionally distraught, angry and/or in denial that they are infected. Two-thirds of the consumers accepted the fact that they are infected, but did not believe that they could live with the virus. These consumers tended to be fatalistic in their views about living with the virus. Four of five consumers who accepted the diagnosis were angry and felt cheated out of a happy life due to the virus. The case analyses indicate that female participants are more likely to feel guilty and ashamed that they have the virus. Three-fourths of the consumers who felt guilty and ashamed were female. Because of the heavy burden of shame and guilt, these consumers take longer to reach a stage where they can begin learning about the disease.

Differences in the emotional and mental state of the consumers appear to be related to whether or not the diagnosis was new at the time they enrolled in the EICMP or whether the diagnosis was made earlier. The mean time lapse between the diagnosis and enrollment in the EICMP is 3.6 years with a range from 1.2 months to 13.2 years. EICMP consumers whose original diagnoses were more than a year earlier had already been through the various stages of denial, anger, and blaming. Some of these consumers rejected the initial diagnosis and failed to begin treatment. Others began treatment and discontinued it because they felt that they no longer needed to be treated. It is only after an acute episode of illness that these consumers were convinced that medical treatment and counseling are beneficial to them.

Forty-seven percent of the consumers participating in the EICMP were ill when they were referred to CCHER.

In the in-depth interviews consumers were asked to reflect on the counseling experience. Most felt that the counseling helped them to come to terms with the disease and to decide to live rather than die. The effect of counseling in coming to terms with the reality of living as a HIV infected individual are reflected in consumer descriptions of their experiences in the EICMP. One consumer describes herself as being unable to purchase clothes or household goods because she knew she was going to die and would not need them. She comments:

" When I came here (CCHER), I saw all these people who were in good shape, I didn't believe it! I didn't know who had HIV and who didn't. The peer counselors were saying, a lot of those people here have it (HIV). When I came here, everyone (counselors) talked with me, they called me on the phone... now I have decided to live."

The counseling also provided the individual a sense of belonging to a supportive community. One consumer describes the experience this way:

"The first day I participated in CCHER I didn't come to see them, in the contrary they came to see me and give me assistance, because I was very sick and they thought it necessary to come give me support."

After the initial visit the consumer reports,

"They (counseling staff) talked with me on the phone, they called me every little time (frequently). I thought I was alone, but when I met the staff I saw I wasn't alone."

Over half of the consumers who disclosed to family and friends that they are HIV infected after entering the EIMCP program indicated that the counseling helped them to make this decision. For example, one consumer states:

"CCHER made a lot of changes in my life. A long time ago, I found it was a big deal for me to talk about HIV and AIDS. Now I am at ease to talk about it, I can even tell people I have HIV ."

Another consumer describes the effect of counseling in helping her disclose this way:

" I was hiding, I didn't yet want anyone to know that I am HIV positive. But after I came to counseling I made the decision to reveal that I have HIV. I saw that this organization (CCHER) is a place that I can come. And I come here, and I love it very much."

As consumers progress through Phase III of the intervention they become more informed about the virus and how it is transmitted. Most consumers reported that they understand and accept responsibility for the preventing the spread of the virus.

Many of the consumers are ready to take preventive measures to prevent the transmission of the virus, but they are not ready to disclose to others that they are infected. This comment is reflective of most of the consumer's attitudes:

"If I found a good man now, how could I tell him I have the virus? It's not that I wouldn't like to tell him, no, but if I tell him he might reject me. If he doesn't have the virus already, I will protect him. I will just tell him that I want to use condoms, that's all, and if he will use them, fine, but if not, then I will just say okay, forget it."

This individual's comments reflect many of the consumers' assessment of the counseling.

"I am better educated about the disease, because I had no information about it at all. I thought that if a person got it today they would die tomorrow, they wouldn't have many days to live, but now I know differently because of the training I got from CCHER. Now I know the difference, for example, between *HIV* and AIDS."

Table 7

EICMP Employee Disclosure of HIV Status

Disclosure	Percentage Distribution (N=53)		
	Pre-Intervention	Post-Intervention	Assimilation Follow Up
I am afraid to tell people that I have HIV	84.62	86.79	90.57
I feel comfortable telling some people I have HIV	82.69	81.13	90.57
I have not told anyone that I have <i>HIV</i>	19.23	16.98	9.43
I have not told my spouse/partner that I have HIV	34.62	24.53	37.74

The consumers also indicated that counseling helps them to become more comfortable talking about the disease. The survey data presented in Table 7 shows that consumers are more comfortable telling some people about their HIV status and that there was a decrease in the percentage of consumers who have not disclosed to anyone about their HIV status after completion of the intervention. Table 8 shows that consumers who are able to talk to someone about their HIV status, in rank order are likely to talk to: a counselor, a family member, a friend, a minister, folk healer. Over 75 percent of the consumers prefer to talk to their counselor. These data are consistent with the in-depth interview data that the consumers find emotional security in their relationships with the counselors and their peers.

Table 8

Individual EICMP Enrollee Feels Most Comfortable to Talking to About HIV/AIDS

Individual	Percentage Distribution (N=S3)		
	Pre-Intervention	Post-Intervention	Assimilation Follow Up
Folk healer	7.69	1.89	7.55
Minister	17.31	7.55	16.98
Counselor	61.54	56.60	75.47
Elder	5.77	0.00	3.77
Family Member	38.46	43.40	43.40
Friend	19.23	20.75	20.75

**Peer Educators and Support Group.** Two important components of the intervention are the peer educators and support group. These components enhance the effectiveness of counseling and education. The peer educators are consumers who provide support to other consumers. The peer educator plays an important social marketing role in that they are living examples for their peers to see that one can live a successful life as an HIV -infected person. They are very effective in reaching the very hard-to- reach consumers who have a fatalistic attitude about being HIV infected. The influence of the peer educators is captured in this statement:

"I did not want to hear my counselor tell me anything, then she brought the peer educator. The peer educator told me he had HIV for 10 years and I could see that he is living and looked good. Then I knew, if he can live with the virus, so can I."

The peer educators have been very influential in getting the consumers to become involved in the support group. The support group provides a continuation of counseling for the intervention completers. The group provides a place for persons who have completed the intervention and consumers who are at various phases of the intervention to provide support to each other. This comment is an indication of the consumers' appreciation:

"I like the support group a lot, because that is where I meet other people who have the same problem as me, we dialog along with the staff."

Another consumer states: "the support made me feel that I am not alone in my fight with this disease."

**Post- Intervention and Assimilation.** Once the consumer has completed Phase III of the intervention, the same instruments used to gather baseline information about knowledge, beliefs, attitudes and risk behaviors, services utilization patterns, and adherence to treatment is administered. During Phase N, a follow-up interview is conducted within six-months after completion of the curriculum using the same instrument. Also, a client satisfaction survey is administered. Upon completion of the follow-up interview the consumer received a \$40 stipend. Completers include only those consumers who have completed the follow-up interview. Data collected from the 53 consumers who completed the Phase IV were used to measure the outcome of the intervention.

Table 9

EICMP Enrollee Service Encounters

Services Provided	Number Consumer Encounters (N=70)
Meals	4,055
Case Management/Advocacy	2,506
Counseling Services	1,146
Housing	1,005
Peer Support	256
Legal Services	71
Vocational Training	35
Substance Abuse Services	18
Translation Crisis Intervention	11
Family Planning	4

**Other Support Services.** In addition to counseling and education, the individuals receive other services. Table 9 shows the approximate number of consumer encounters in which other services were requested. Encounters refer to requests made for services. Some of these requests were not provided due to lack of service availability in the community. During the three-year period, approximately 1,146 encounters were made for counseling services, 1,005 for housing services, 4,055 for meal service, 35 for vocational training, 18 for substance abuse services, and 71 for legal services, 5 for family counseling, 11 for crisis intervention, 2,506 for case management/advocacy, and 256 for peer support.

## Summary of Process Findings

Overall, the intervention was implemented as planned. The findings reveal that about one third of the consumers initially come to the agency as a result of an acute illness that required medical attention. However, 42 percent were referred from other CCHER programs. Many of the consumers did not have family or friends in the Boston area, or were kicked out by family when it was discovered that they are HIV infected. The services most frequently sought are housing and food services. Once these needs are met, consumers enroll in the psychosocial educational counseling component of the EICMP.

Features of the psycho-social educational counseling that caused the consumer to continue through completion are: (1) the consumers feel counselors are not judgmental (2) they feel that knowledge they receive helps them to understand their illness, and (3) the counselors help them with all of their needs from problems with the schools to problems with the landlord. The in-depth interviews provide clear evidence that the most important benefits from the perspective of the consumers are: (1) the sense of belonging to caring community, (2) restoration of the will to live, and (3) becoming more informed about the disease, the treatment, and how to live a successful life as a HIV -infected person. The knowledge described by the consumers as beneficial to them included: (1): terminology that explains the disease so that they understand the doctor's interpretation of the test results (e. g.. T-cell counts), (2) information about risk reduction, methods of transmission, treatment adherence and (3) information about the relationship between treatment adherence and living successfully with HIV. Also, it is clear from the in-depth interviews that the trust relationship with the counselor is a very important component and that it is enforced by a common language and cultural understanding between the counselor and the consumer. In the in-depth interviews consumers' reflections suggest that the one-to-one counseling with the same person over time plays an important role in keeping consumers actively engaged in educational counseling.

## Outcome Evaluation Findings

***Knowledge of HIV/AIDS.*** In the in-depth interviews, consumers describe the knowledge they gained from educational counseling as one of the greatest benefits from participation in the intervention. The case notes also indicate that the majority of the consumers had little knowledge of how HIV is transmitted and the relationship between the treatment and the chances of living successfully as a HIV -infected individual. According to the case notes, 55 percent entered the EICMP with little knowledge about the virus, 43 percent had some basic knowledge and 2 percent were well informed about the disease. In the in-depth interviews the consensus among the consumers is that the knowledge gained in the counseling helped them to understand the disease. This comment captures the consumers' perceptions of increase in awareness and knowledge of HIV/AIDS:

"I am better educated about the disease. I had no information about it at all. I thought that if a person got it (HIV) today they would die tomorrow, they wouldn't have many days to live, but now I know differently because of the training I got from CCHER. Now I know the difference, for example, between HIV and AIDS."

Other consumers contribute knowledge gained from the counseling to helping them understand the importance of adherence to their treatment.

"The most important thing I learned is about the treatment. Now I know what the medicine is doing for me and why I need to take it. I also know that if I do what the doctor tells me to I can stay well. I can talk to my doctor better. I understand the terms he uses to describe my test and I understand his instructions better than before."

Knowledge also had an influence on risk behavior. As the consumers learned more about the disease and lifestyle factors that affect treatment, some consumers reported changes in behavior. This statement reflects the effect that the increase in knowledge had on some of the consumers:

"The things I learned here (CCHER), my counselor talked with me about how this disease gets into people, how you can get it. I used to drink alcohol, I don't drink anymore. I used to go with girls, I don't do that any more at all. They (counselors) tell me, not to take drugs, not to do this and that, I take it and I hold it in my head and I follow it."

The qualitative data describe above is supported by the survey data presented in Table 10, which shows that there was a 20 percent increase in the EICMP consumers reporting that drinking is a serious health risk. The pre and post survey data presented in Table 11 and the comparisons made between the EICMP emoltees and the non-EICMP emoltees presented in Table 12 confirm that the consumers' knowledge increased.

Table 10

Comparison of EICMP Emollee Beliefs, Attitudes  
HIV Risk Behaviors Measures

Beliefs, Attitudes and HIV Risk Behaviors	Percentage Distribution (N=53)		
	Pre-Intervention	Post-Intervention	Assimilation Follow Up
Drinking of any amount is a serious health risk	61.54	79.25	81.13
Drinking alcohol is wrong	65.38	84.91	79.25
Supernatural powers can cause individuals to become ill	63.46	56.60	64.15
Using any kind of drug is wrong	92.31	96.23	94.34
Engages in unprotected sex	21.16	20.75	7.55

Table 11 shows that greatest increase was in knowledge about condom use with a change from 59 percent to 81 percent of the consumers being aware that latex condoms reduce the risk of transmitting the HIV through sexual contact. At the Sallie time there was a 40 percent increase (from 36 percent to 76 percent) in the consumer's understanding that sheep skin condoms do not protect one from the transmission of the HIV through sexual contact. Table 12 shows that overall, the EICMP enrollees were more knowledgeable than the non-enrollees. There is a 17 percent difference in the overall percentage of HIV consumers who were knowledgeable of HIV/AIDS and how it is transmitted. Sixteen percent more EICMP enrollees understand that one can contract HIV from having sex without a condom than did the comparison group. Fifteen percent more EICMP enrollees than the comparison group understands that pregnant women can give the virus to their unborn babies.

***Reduction in Risky Behavior.*** Both the in-depth interviews and the survey data show a reduction in the percentage of the EICMP participants who engage in unprotected sex. Data presented in Table 10 indicate that there was a 14 percent reduction in the EICMP consumers who engage in unprotected sex. Even among those participants who were not willing to disclose their HIV status to their sexual partners, efforts were made to protect the partner. Also, Table 15 shows that in pre- and post-intervention comparisons, there was a 17 percent increase in the percentage of the EICMP consumers who reported that they brought their partner in for HIV testing.

***Adherence to Treatment.*** Adherence to treatment was measured by whether or not consumers keep medical appointments and take their medication. The data presented in Table 13 show that between the pre- and post-test the percentage of persons who keep their medical appointments most of the time increased by 8 percent. However, between the post-test and the assimilation period the percentage of consumers who kept their medical appointments most of the time declined by 2 percent. This represents an overall net gain of a 6 percent increase in the percentage of the consumers who keep most medical appointments. According to the data presented in Table 13, medication adherence declined between the pre and post-test by 11 percent and increased between the pre-intervention and assimilation period, representing a 4 percent increase in consumers who reported that they always take their medication. At the opposite end of medication adherence, there was a 2 percent decrease in the percentage of the consumers who reported that they never take their medications. Data presented in Table 14 show that there was a decline in all of the reasons given for not taking medications except forgetting to take the medication. The largest decline was in "not taking the medication due to dislike of the side effect," which declined by 20 percent. The post-intervention survey data reveal that overall, the percentage of consumers reporting that they keep appointments. There was modest change in medication adherence practices. The lack of change is not negative in that the adherence rates were between 90 percent and 85 percent prior to the intervention.

Table 11  
Comparison of EICMP Emollée Pre and Post Measures of Knowledge About HIV/AIDS

Knowledge About HIV/AIDS	Percentage Distribution (N=53)		
	Pre-Intervention	Post-Intervention	Change
Understands what <b>HIV</b> is	86.8	92.5	5.7
Understands what AIDS is	75.5	90.6	15.1
Understands what testing HIV positive means	75.5	88.7	13.2
Understands where the HIV lives in the human body	88.7	88.7	0
Understands that one cannot tell if a persons has <b>HIV</b> by looking at them.	73.6	94.3	20.7
Understands that the use of latex condoms during sex reduce the risk of getting HIV	58.5	81.1	22.6
Understands that using sheep skin condoms during sex does not reduce the risk of getting HIV	35.9	75.5	39.6
Understands that a person who has many sexual partners have a greater chance of getting HIV	88.7	96.2	7.5
Understands that HIV is not transmitted from a toilet seat	84.9	94.3	9.4
Understands that one cannot get HIV from hugging and touching someone who has it	77.4	90.6	13.2
Understands that cleaning a with bleach and water helps to prevent one Conn getting HIV	35.9	54.7	18.8
Understands that one can contact the HIV virus through anal sex without a condom	84.9	96.2	11.3
Understands that a person who has the HIV virus has a higher risk of developing Tuberculosis	90.6	98.1	7.5
Understands that it is possible for a pregnant woman who has <b>HIV</b> to give it to her unborn baby	81.1	90.6	9.5
Understands that one can get the <b>HIV</b> virus from having oral sex without a condom	66	83	17
Understands that Penicillin can not effectively treat all Sexually Transmitted Diseases	17	15.1	-1.9
Understands that a person can get HIV from having vaginal sex without a condom	88.7	90.6	1.9
Understands that HIV is not transmitted by kissing someone on the lips	79.3	81.6	2.3
<b>OVERALL AVERAGE</b>	<b>71.6</b>	<b>83.5</b>	<b>11.9</b>

Table 12

## Comparison of EICMP Enrollee and Non-EICMP Enrollee Knowledge About HIV/AIDS

Knowledge About HIV/AIDS	Percentage Distribution		
	EICMP Enrollee (N=53)	Non-EICMP Enrollee (N=33)	Difference
Understands what <b>HIV</b> is	92.5	75.8	16.7
Understands what AIDS is	90.6	60.6	30.0
Understands what testing HIV positive means	88.7	66.7	22.0
Understands where the <b>HIV</b> lives in the human body	88.7	75.8	12.9
Understands that one cannot tell if a persons has HIV by looking at them.	94.3	84.9	9.4
Understands that the use of latex condoms during sex reduce the risk of getting HIV	81.1	45.5	35.6
Understands that using sheep skin condoms during sex does not reduce the risk of getting HIV	75.5	12.1	63.4
Understands that a person who has many sexual partners have a greater chance of getting <b>HIV</b>	96.2	90.9	5.3
Understands that HIV is not transmitted from a toilet seat	94.3	84.9	9.4
Understands that one cannot get HIV from hugging and touching someone who has it	90.6	93.9	3.3
Understands that cleaning a with bleach and water helps to prevent one fonn getting HIV	54.7	24.2	30.5
Understands that one can contact the HIV virus through anal sex without a condom	96.2	78.8	17.4
Understands that a person who has the HIV virus has a higher risk of developing Tuberculosis	98.1	87.9	10.2
Understands that it is possible for a pregnant woman who has HIV to give it to her unborn baby	90.6	75.8	14.8
Understands that one can get the HIV virus from having oral sex without a condom	83.0	66.7	16.3
Understands that Penicillin can not effectively treat all Sexually Transmitted Diseases	15.1	6.1	9.4
Understands that a person can get HIV from having vaginal sex without a condom	90.6	90.9	0.0
Understands that HIV is not transmitted by kissing someone on the lips	81.6	87.9	-6.3
<b>OVERALL AVERAGE</b>	<b>83.5</b>	<b>67.2</b>	<b>16.7</b>

Table 13

## EICMP Emollee Adherence to Treatment

Adherence	Percentage Distribution (N=53)		
	Pre-Intervention	Post-Intervention	Assimilation Follow Up
Keeping most medical appointments	86.54	94.34	92.45
Always take medications	73.08	62.26	77.36
Sometimes take medications	21.15	32.08	16.98
Never take medications	1.92	3.77	1.89

Table 14

## EICMP Emollee Reasons for Not Taking Medication

Reasons for Not Taking Medication	Percentage Distribution (N=53)		
	Pre-Intervention	Post-Intervention	Assimilation Follow Up
Forgot to take medication	9.62	5.66	7.55
Don't think that the medication helps	7.69	1.89	1.89
Prefer to take home remedies	11.54	13.21	3.77
Don't like the side effects of the medication	21.15	24.53	7.55
Believe the medication is bad for me	13.46	5.66	3.77

**Utilization of Services.** The pre and post-intervention data presented in Table 15 show that the EICMP consumers reported that they use more community-based social services and medical services and less emergency and inpatient services. Table 15 reveals that the percentage of consumers reporting that they use emergency room services decreased by 21 percent and the percentage using inpatient medical services decreased by 19 percent. There was an increase in the percentage of consumers using housing services, 11 percent; outpatient medical services, 11 percent; HIV -related home care, 11 percent; self-help group, 26 percent; and vocational training, 17 percent. Ninety-six percent reported using HIV -related medical services and 91 percent reported using outpatient medical services. In comparison to the EICMP participants, the comparison group used fewer services. According to the data presented in Table 16, the only areas in which the comparison group consumes more services than the EICMP participants are pharmacy, family counseling, and mental health, and dental services.



**Outpatient medical** services

Emergency room services

**Inpatient medical** services

**HIV-related medical** services

HIV-related self-care

**HIV-related** home care

Mental **health** services

Self-help group

**Family counseling Pharmacy**

Pre-Intervention

25.5

46.8

27.7

80.9

44.7

38.3

91.5

31.9

2.1

23.4

19.2

12.8

85.1

Post-Intervention

36.2

40.4

27.7

91.5

23.4

19.2

95.7

27.7

12.8

27.7

44.7

10.6

89.4

Change

10.6

-6.4

0.0

10.6

-21.3

-19.2

4.3

-4.3

10.6

4.3

25.5

-2.1

4.3

Vocational **training** Case management

**HIV** testing for partner or friend

Prenatal pregnancy care

OVERALL AVERAGE

19.2

76.6

6.4

8.5

37.7

36.2

83.0

23.4

6.4

40.9

17.0

6.4

17.0

-2.1

3.3

Table 16

Comparison of EICMP Enrollee and Non-EICMP Service Utilization

Percentage Distribution

**EICMP Enrollee (N=53)**

Services Received

Housing or shelter

36.2

Food or other basic needs

40.4

**Dental services**

27.7

Outpatient medical services

91.5

Emergency room services

23.4

**Inpatient medical services**

19.2

HIV -related medical services

95.7

HIV-related self-care

27.7

HIV-related home care

12.8

**Mental health services**

27.7

Self-help group

44.7

Family counseling

10.6

Pharmacy

86.4

Vocational training

36.2

**Case management**

83.0

HIV testing for partner or friend

23.4

Prenatal pregnancy care

6.4

**OVERALL AVERAGE**

40.7

**Non-EICMP Enrollee (N=33)**

6.1

12.1

33.3

69.7

21.2

18.2

76.8

15.2

21.2

30.3

39.4

18.2

100.0

12.1

75.8

6.1

0.0

32.7

Difference

30.1

28.3

-5.7

21.8

2.2

1.0

19.0

12.5

-8.4

-2.6

5.3

-7.5

-13.6

24.1

7.2

17.3

6.4

8.1

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Table 17

I

Comparison of EICMP Enrollee Pre and Post Measures of Barriers to HIV/AIDS Services

Barriers to HIV/AIDS Services

Consumer does not think service exit

Consumer does not know where to go for services

Consumer feels he/she has to wait too long for services

Consumer feels the service costs too much

Consumer feels she/he is ineligible to receive services

Consumer feels the people who run the service do not like her/him

Consumer feels that transportation to get to services is difficult

Consumer does not know what to do with the kids while getting services

Consumer afraid that others will find out that she/she has HIV

Consumer is afraid that he/she will not be treated if they go for service

Consumer afraid they might lose her/his child

Consumer afraid that someone might force her/him to take medication

Consumer finds it difficult to make or keep appointment

The people **at** the agency do not speaking **the** same language as **the** consumer

The consumer has trouble telling the people at the agency what he/she needs

The consumer worries that family and friends will not approve of the service

The consumer is caretaker for other people and can not take the time to get service

OVERALL AVERAGE

Pre-Intervention

Percentage Distribution (N=53)

I Post-Intervention I

35.3

33.3

35.3

29.1

29.4

21.6

13.7

2.0

33.3

23.5

31.4

25.5

43.1

39.2

25.5

21.6

13.7

23.5

3.3

0.0  
3.9  
0.0  
3.9  
2.0  
23.5  
23.5  
25.5  
29.4  
25.5  
15.7  
11.8  
7.8  
47.1  
37.3  
23.8  
19.7  
Change  
-2.0  
-6.2  
-7.8  
-11.8

-9.8  
-5.9  
-3.9  
-3.9  
9.8  
-3.3  
-3.9  
-2.0  
0.0  
3.9  
-9.8  
-3.9  
-9.8  
-4.1

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Table 18

Comparison of EICMP Emollee and Non-EICMP Perceptions of Barriers to HIV Service

Percentage Distribution

Barriers to HIV/AIDS Services

Consumer is not aware that the service exist

Consumer does not know where to go for services

Consumer feels he/she has to wait too long for services

Consumer feels the service costs too much

Consumer feels she/he is ineligible to receive services

Consumer feels the people who run the service do not like her/him

Consumer feels that transportation to get to services is difficult

Consumer does not know what to do with the kids while getting services

Consumer afraid that others will find out that she/she has HIV

Consumer is afraid that he/she will not be treated if they go for service

Consumer afraid they might lose her/his child

Consumer afraid that someone might force her/him to take medication

Consumer finds it difficult to make or keep appointment

The people at the agency do not speak the same language as the consumer

The consumer has trouble telling the people at the agency what he/she needs

The consumer worries that family and friends will not approve of the service

The consumer is caretaker for other people and can not take the time to get service

OVERALL AVERAGE

**EICMP Enrollee (N=S3)**

33.3

29.4

21.6

2.0

23.5

25.5

39.3

21.6

23.5

0.0

0.0

2.0

23.5

29.4

15.7

7.8

37.3

19.7

**Non-EICMP Enrollee**

(N=33)

15.2

12.1

24.2

0.0

15.2

15.2

27.3

12.1

30.3

18.2

9.1

6.1

9.1

78.8

15.2

6.1

42.4

19.8

Difference

18.2

17.3

-2.7

2.0

8.4

10.3

12.1

9.5

-6.8

-18.2

-9.1

-4.1

14.4

-49.4

0.5

1.8

-5.2

-0.1

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Table 19

Comparison of EICMP Enrollee Pre and Post Measures of Conditions that Facilitate Use of HIV/AIDS Services

Percentage Distribution (N=53)

Facilitators of HIV/AIDS Service Use

People at the agency seem to care about the consumer

Food is provided for consumers by the agency

Services include more than health care services

Child care is provided for the consumers

The agency is located near where the consumer lives

Consumers feel they learn important things at the agency

Transportation is provided for consumers

It is easy for consumers to talk to the people at the agency

The agency provides consumers appointments at convenient times

The consumers like the people they meet at the agency

The consumers feel the parking areas at the agency are safe

OVERALL AVERAGE

Pre-Intervention

94.1

47.1

7.8

11.8

49.0

90.2

23.5

92.2

96.1

96.1

84.3

62.9

Post-Intervention

92.2

45.1

33.3

5.9

41.2

92.2

29.4

96.1

98.0

98.0

86.3

65.2

Change

2.0

2.0  
25.5  
-5.9  
-7.8  
2.0  
5.9  
3.9  
2.0  
2.0  
2.0  
2.0  
2.3

Table 18 shows that the greatest barrier to service utilization for the comparison group was language, with 79 percent reporting language as a barrier compared to 24 percent of the EICMP consumers reporting language as a barrier. This 49 percent disparity validates the assumption that language is an important factor in making *HIV* consumer services accessible to Haitians. Thirty percent of the comparison group reported that they fear that someone would find out that they have HIV to be a barrier to service utilization. Almost 20 percent reported being afraid that they would not be treated if they sought medical care and 9 percent were afraid that they might have their children taken from them. There was no additional information provided concerning why the comparison group felt they would not be treated.

In addition to identifying barriers, consumers were asked to identify those conditions that made it easier for them to utilize services. The only area in which there was a significant change was the awareness that services for HIV consumers included more than health care. Table 19 shows that there was a 24 percent increase in the number of consumers reporting that their awareness of non-medical services available to them increased their utilization of services. Comparisons between the non-EICMP comparison group and the EICMP consumers presented in Table 20 show that the greatest differences in the two groups are in

feeling safe in the parking areas, transportation, and the provision of food. The percentage of EICMP consumers who felt that the parking areas at the agency are safe was 29 percent higher than the comparison group. To the contrary, the percentage of the EICMP consumers that reported transportation as a facilitator was 31 percent less than the comparison group. Forty-five percent of the EICMP consumers and 21 percent of the comparison group reported that food provided by the agency facilitates utilization, representing a 24 percent difference between the two groups.

Table 20

### Comparison of EICMP Enrollee and Non-EICMP Conditions that Facilitate the Use of HIV Service

#### Percentage Distribution

#### Facilitators of HIV/AIDS Service Use

People at the agency seem to care about the consumer

Food is provided for consumers by the agency

Services include more than health care services

Child care is provided for the consumers

The agency is located near where the consumer lives

Consumers feel they learn important things at the agency

Transportation is provided for consumers

It is easy for consumers to talk to the people at the agency

The agency provides consumers appointments at convenient times

The consumers like the people they meet at the agency

The consumers feel the parking areas at the agency are safe

#### OVERALL AVERAGE

#### **EICMP Enrollee** (N=53)

92.2

45.1

33.3

5.9

41.2

92.2

29.4

96.1

98.0

98.0

86.3

65.2

**Non-EICMP Enrollee (N=33)**

84.9

21.2

27.3

15.2

36.4

90.9

60.6

97.0

97.0

93.9

57.6

62.0

Difference

7.3

23.9

6.1

-9.3

4.8

1.3

-31.2

.<J.9

1.1

4.1

28.7

3.3

The importance of the food service is also discussed by consumers in the in-depth interviews. This consumer's comments capture the general feelings of the consumer regarding the food:

"I like the food deliveries they (CCHER) do for people who can't cook. There was a time when I got this because I couldn't cook for myself. Now, I can cook, so I

discontinued it, but when I couldn't it helped me a lot, and I would like that service to continue for other people."

Nine percent fewer of the EICMP consumers than the comparison group reported that the provision of child care is a facilitator in the use of services.

Overall, the difference in the percentage of EICMP and comparison group consumers who perceived that barriers to services existed was low. There was less than a one percent mean difference between the EICMP participants and the comparison group perceptions of barriers. Comparisons between the pre- and post-intervention reporting of barriers by the EICMP consumers presented in Table 17 reveal that the overall average change was 4 percent. The average overall difference between the percentage of EICMP consumers and comparison group consumers reporting conditions that facilitate services use is 3 percent. The mean percentage change in pre and post-intervention comparisons of the EICMP consumers was only 2 percent. These data suggest that overall, there were no major changes in service utilization or the perceived barriers and conditions that facilitate service use.

***Sense of Well Being.*** Objective and subjective data were used to determine the consumers' sense of well being. The in-depth interviews and case notes provided information about family and friendship networks as important sources of social support. The best functioning ratings and the CESDS were used to provide objective data about the consumers' sense of well being. The in-depth interviews and the case note data reveal that the status of family relations with the consumer is important to the consumer's sense of well being. The family either already knew about the HIV status of the consumer and accepted it, did not know about the diagnosis, or knew about it and rejected the infected family member prior to the consumer's enrollment in the EICMP. The consumers who had disclosed their HIV status to family members and were not rejected received support from the family.

However, one-fourth of the consumers were rejected by their family when they learned that the consumer was HIV infected. Half of the consumers had not told their immediate family fearing rejection. The reasons given for rejection were that the family would feel they are immoral, or loose, meaning that they engage in sex indiscriminately. The fear of being labeled as immoral is strongest among female consumers. Some even suggested that the family would accuse them of being sex workers. Even married women whose husbands transmitted the virus to them did not want to disclose to family. For these individuals the fear of social ostracism is too great.

Male consumers did not have the same family issues as the females. The men were likely to accept the fact that the virus was transmitted through sexual contact. Their relationships with their family were not altered. Only in one case was it reported that the family rejected the male member. In this case the consumer's brother-in-law, who was providing the consumer housing while he was in the United States, threw him out because he had transmitted the virus to his sister, the consumer's wife. The greatest fear among the male consumers is that the community would reject them because of fear that the disease can be transmitted through



casual contact.

The data suggest that the family relations were already established prior to entering counseling. In the absence of strong family support the EICMP program became the surrogate family. The intervention provided a safe and a supportive environment for individuals to cope with family the rejection. The consumers reported that one of the most important benefits of the intervention was that they felt cared about. The counseling sessions and support group provided the consumers a place to come for emotional support and validation of individual worth. The following comments summarize the perceptions of most consumers regarding the impact of the counseling in developing a sense of emotional security:

" When I come here (CCHER)I feel like I am with my family, I feel at ease because they (the CCHER staff) consider me the same as them."

" I felt that the counseling was good for me, because I was very depressed and it made a big change in me. I'm okay now, I consider CCHER as a family for me, because not only do they help me in everything that I need, but they speak the same language as I do."

A consumer who is still working through personal issues states:

"Some days I am very depressed, and I ask God, why? But I always find someone here (CCHER), when I feel that way. I usually talk with my counselor. I was depressed, I had panic attacks last year. But here, every day, my counselor talks with me, I explain my problems and he talks to me, he says don't ever hesitate to call.I feel like I am not alone anymore."

Some consumers feel a sense of security knowing that they are not alone in their attempt to live successfully with the virus. This comment describe this feeling:

" What has happened to me because of coming to CCHER, I think it has happened to a lot of other people too. I used to feel like I was the only one with HIV. But since coming to CCHER, I see people I used to see in the street, and I never knew that they had HIV. This is a base for me now, I am not the only one in the house."

The EICMP consumers find a surrogate family at CCHER. The support group members provide support to each other. The community that has developed reinforces the commitment to live successfully and to help others to do so. At CCHER consumers begin to believe that their lives are not over. These statements reflect the consumers' personal feelings about the experience:

"What was the most important thing for me was that my counselor let me know, you



are a person just like everyone else, you can do everything as long as you take care of yourself, that gave me a lot of hope."

"I had just lost my husband and I had just lost my mother, within three months. I came here.(CCHER) I got a good reception, that gave me strength too. I was happy to come here. The counselor has helped me understand that I can go on."

The theme throughout the in-depth interviews was that the consumers made a commitment to live with HIV due to the counseling intervention. They received hope and a sense of belonging to a valuable community that cares about them and is there for them during bad times. This outcome is confirmed in the survey data presented in Table 21. The Table reflects a 30 percent increase in the pre and post comparisons of the number of individuals who rated their social functioning as very high.

The best functioning ratings presented in Table 2 I show that the 0 overall health rating increased 4 percent between. Other increases in best functioning ratings were in the categories of: current perception of health, 5 percent increase; emotional well being, 6 percent increase; social functioning, 30 percent increase; physical functioning 20 percent increase. There was no increase in the percentage reporting best functioning in cognitive function.

Table 21

EICMP Emollée Sense of Well Being: Best Functioning Ratings

Area of Best Functioning	Percentage Distribution (N=53)		
	Pre- Intervention	Post-Intervention	Change
Overall Health	20.8	25.0	4.2
Current Perception of Health	8.3	12.5	4.2
Emotional Well Being	2.1	8.3	6.3
Cognitive Functioning	25.0	25.0	0.0
Social Functioning	35.4	64.6	29.2
Physical Functioning	37.5	58.3	20.8

The data in Table 21 indicate that the largest increases in the percentage of the consumers' rating of best function before and after the intervention are in the areas of social and physical function. These data are consistent with the in-depth interviews and the analysis of case notes. In-the in-depth interviews, several consumers talked about the degree to which the counseling and support group provided them an alternative to social isolation. These comments are consistent with the comments made by many of the consumers:

" When I come here I find support. Because I don't have relatives here (in the United

States). I don't have family here, I have only one sister. And that sister really doesn't have time for me because she has two children."

"When I first came here (CCHER), I was afraid that they would tell other people about me. Now I feel that this is my house. I didn't used to go out, I stayed at home with my computer and telephone, but since I have been coming to CCHER, it's different. I come to CCHER's activities. Other organizations don't have parties, they don't do things for the children."

In the case notes, a pattern of involvement in the activities occurs after the sixth curriculum session. Most of the EICMP consumers begin coming to events such as holiday parties, retreats, and other activities. Over half are active support group participants. The level of social interaction increases as the consumers' level of trust builds. The trust is built through the counselors who show considerable respect for the consumers. Consumers are treated with dignity, which validates their worthiness as human beings. These consumers' statements are representative of what most consumers feel about their experience at CCHER.

"What was most helpful to me was the way they (counselors and case managers) appreciated me when I came here."

" My counselor helped me to understand that this can happen to anyone. He let me know that it did not happen to me because I am bad or loose. I feel much better about myself since coming here (CCHER).".

Other EICMP consumers state that they no longer feel they are bad people because they have the virus.

Manifestation of the physical well being is also supported in the in-depth personal interviews with consumers. Most are pleased with their health and ability to conduct the normal activities of daily living. Additionally, the pre and post-intervention rating of depression using the Center for Epidemiological Studies Depression Scale reveal that the E ICMP

consumers are less depressed after completion of the intervention. The pre-intervention mean rating for the EICMP consumers on the 20-item scale was 18.06 and the post-intervention rating was 12.77. When compared to the comparison group the ratings were 18.48 for the comparison group and 12.77 for the EICMP consumers.

***Satisfaction with Case Management and Related Services.*** Consumer satisfaction data presented in Table 22 indicate that the consumers are very pleased with the staff. Yet, only 37 percent rated the overall services of the agency as excellent prior to the intervention and 45 rated it as excellent after the intervention, representing an 8 percent change. Prior to the intervention 37 percentage of the consumers rated the information as helpful and after the intervention 55 percent rated the information as helpful, representing a 18 percent increase. Table 22 shows that the areas that gained the most after the intervention are related to staff



providing information about treatment procedures (from 68 percent to 95 percent) and staff treating each individual as a unique person (from 74 percent to 95 percent). The percentage reporting the availability of staff to help when the consumer has questions increased from 76 percent to 95 percent. The survey data are consistent with the data provided in the in- depth interviews.

Table 22

## EICMP Enrollee Satisfaction with CCHER Services

### Areas of Satisfaction

Overall **the** services are excellent

The information has been helpful

The staff here answers my questions all of the time

The staff here always tells me **in** advance about treatment procedures that I should have

The always staff here treats me like I am an individual with unique needs and concern

The staff always respects my privacy

The staff here is always available to help me when I have questions

I would definitely they should come needs like mine.

tell my friends that here if they have

My counselor is kind to me

My counselor is considerate of my feelings

My counselor definitely takes interest **in** me as a person

My counselor definitely respects my beliefs about health

My counselor understands what I tell him/her about my problems

My counselor always explains what I need to do to pursue treatment

My counselor does not treat me poorly because I am Haitian

I am very comfortable asking my counselor questions

OVERALL AVERAGE

Pre- Intervention

Percentage Distribution (N=53)

I Post-Intervention

36.8

44.7

36.8

55.3

76.3

89.5

68.4

94.7

73.7

94.7

86.8

100.0

76.3

94.7

86.8

97.4

97.4

97.4

94.7  
97.4  
76.3  
89.5  
76.3  
94.7  
89.5  
97.4  
84.2  
94.7  
76.3  
84.2  
86.8  
97.4  
76.5  
89.0  
Change  
7.9  
18.4  
13.2  
26.3  
21.1

13.2

18.4

10.5

0.0

2.6

13.2

18.4

7.9

10.5

7.9

10.5

12.5

**Summary of Outcome Findings**

The EICMP intervention changed the consumer's level of knowledge about the HIV, HIV risk behaviors, treatment adherence, service utilization patterns, sense of well being and satisfaction with CCHER services. Upon entering the program over half of the consumers had little or no knowledge of HIV. Acquisition of knowledge is reflected in the pre and post intervention measures. The EICMP consumers knowledge gain was significant and comparisons between the EICMP consumers and the comparison group indicate that EICMP consumers are more knowledgeable about how the disease is transmitted and preventative practices and life styles than the comparison group.

The EICMP consumers reduced risky behavior by practicing safe sex and by changing life styles, such as eliminating or reducing alcohol consumption. Consumers reported that they are more likely to take their medication. The services the consumers are using have changed over time. They are using more outpatient and less emergency and in-patient medical services. The need for basic service such as food and housing has decreased at EICMP consumers become more healthy and able to resume work to support themselves. The EICMP consumers are more healthy than the comparison group as indicated by the percentage of the comparison group who require in-patient medical care.

Barriers to services differ for the EICMP consumers and the comparison group consumers. Language is a barrier for the comparison group, whereas transportation was reported as a barrier for the EICMP consumers. However, facilitators of service utilization were similar. Both groups reported that following as facilitators: staff cares about consumers, consumers learn important things at the agency, it is easy for consumers to talk to staff, the convenience of appointments, and the consumers like the staff. The EICMP consumers' sense of well being increased, with the largest gains in the social and physical functioning. The EICMP consumers reported being satisfied with the CCHER services and staff.

The outcome findings reveal that consumers did benefit from participation in the EICMP program. As individuals become more knowledgeable, they have more confidence in the treatment. The sense of well being is increased which also contributes to social outreach and a positive attitude about living with the disease. The major findings are that EICMP participants are less dependent on crisis health care than the comparison group and have fewer barriers to utilization of HIV medical and support services.

### **Discussion of the Evaluation Findings**

The EICMP program was designed to address the unique needs of Haitian HIV consumers. The intervention was based on two assumptions, (1) due to cultural and language barriers, Haitians are less likely to adhere to HIV medical treatment advice, to be knowledgeable about the causes of HIV / AIDS and the transmission of the disease, to utilize health and

social services and to reduce risky behaviors, and (2) through one-to-one psychosocial counseling provided in Haitian Creole in a culturally supportive environment and continuity of case management, Haitian HIV consumer's perceptions and attitudes about their susceptibility to and the severity of HIV, and the benefits of and barriers to treatment would change over time. The intervention short-term goals were to change attitudes and behaviors and to increase preventive health care practices.

Overall, the EICMP has been effective in meeting its short-term goals to change attitudes and behaviors among EICMP HIV consumers. Changes that occurred are documented in the pre and post measures and in the comparisons between the EICMP consumers and non-EICMP consumers. These changes are confirmed in the in-depth interviews with consumers and the analysis of the case workers notes. Although the changes overall were modest, there were major changes in knowledge and social and physical well being. It is important to note that changes in these three areas are interrelated.

The evaluation findings suggest that the psychosocial educational counseling is the core feature of the EICMP. It provides education that influences the consumers expectations and belief in the efficacy of HIV treatment, which increases the utilization of services, reduces risky behaviors, and increases adherence to treatment. Psychosocial educational counseling also affects the consumers' level of self-confidence. As consumers become knowledgeable, they are empowered to participate in their treatment as an informed patient. Also, knowledge gained from participation in the EICMP is shared with family. Several of the consumers stated that they use this information to educate their children about HIV and how to protect themselves from becoming infected.

Several consumers commented that if they knew before what they now know, they would not have ever been infected because they would have protected themselves. The survey data collected during assessment and after the assimilation period, the in-depth interviews, and the analysis of case notes indicate that the consumers are more aware of what HIV is, the differences between AIDS and HIV, the modes of transmission, and ways to prevent transmission of the virus. For example, one of the most revealing changes in knowledge is that sheep skin condoms are not effective in preventing transmission of HIV. Knowledge about sheep skin is a critical observation, since the misunderstanding about sheep skin could lead to risky sexual behavior. The consumers also learn about the HIV treatment, what they should expect from the treatment and why it is critical that they continue to adhere to the medication regimens prescribed by the doctor. The EICMP consumers learn about new medical trials and the potential benefits of these trials for them. For the first time many of the consumers could make the connection between the disease and the treatment of the disease

Learning the medical terminology, the purpose for various medical procedures, and explanation of what the test results mean influences medication adherence and the ability of consumers to talk to their doctors. In the in-depth interviews EICMP consumers discuss



that they are now willing to ask the doctor questions about their treatment and to share information that they would not have shared prior to counseling. The knowledge provided to the consumer by the counselors stimulated interest beyond that which is provided by CCHER. Some consumers report that they have begun to seek additional information about the virus. Some of the consumers are not only seeking information for themselves, they are sharing it with others.

Increases in knowledge have led to changes in attitudes and risk behaviors by most of the 53 E ICMP consumers. Most of the consumers report that they are practicing safe sex, avoiding the use of alcohol and other substances that can increase the risk of infections and impair judgment during sexual encounters. There are still some consumers who are having unprotected sex and some who are placing themselves at risk of contacting other infectious diseases that can complicate the *HIV* status.

The findings support the initial premise that language is an important factor in Haitians utilizing HIV services. The magnitude of language as a barrier to service utilization was illuminated by the comparisons between the EICMP consumers and non-EICMP consumers. The importance of language as a facilitator in service utilization also was highlighted in the in-depth interviews. Consumers spoke about the ability to converse in their own language helping them to communicate with the counselors more openly. One can speculate that language also had an effect on building a trust relationship between the counselors and the consumers. Communications were not restricted by the limitations created by the translations of concepts and feelings between languages.

The importance of language and culture in the trust relationship between the EICMP consumers and the CCHER staff cannot be undervalued. One of the themes that was apparent in the in-depth interview data was that trust was built before the consumers fully disclosed information to the counselors. The reasons given for trusting the counselors were: (1) they speak Haitian so there is no need for a third person to translate, which gives the consumer complete privacy in their discussions with the counselor, (2) the counselor accepts the consumer's personal beliefs without being judgmental, and (3) the counselors are one of their own cultural group and therefore are more likely to understand their problems. In the absence of trust, it would have been impossible to provide the level of educational counseling that occurred within this group

The findings revealed that the case management along with counseling is an important aspect of the intervention. Case management is the entry point for many of the consumers. In many cases the consumer enters the agency's service system in crisis. The most frequent crisis is the lack of housing. In some cases the family has rejected the infected member and the individual does not have any place to go. In other cases the individual is too sick to cook for themselves and have no family members. The case managers assist these individuals in securing a safe place to live and provide them hot meals until they are able to provide for themselves. The case managers serve as brokers and interpreters to assist consumers in



finding services throughout the human services network. One of the outcomes of the intervention is that having the same case manager at the hospital and in the community did increase continuity of care. The consumers spoke about the benefits of having a case manager who followed up with them as their needs changed. They particularly appreciated that the case managers were knowledgeable about their needs. As the consumers' needs changed, the case manager was able to recommend services appropriately matched to consumers' needs.

Once the basic needs of the individuals are met, they can begin benefitting from the counseling. The agency provides the individual counseling by telephone or in their place of residence. The option to receive counseling at home was a critical factor in many of the consumer's decision to enroll in counseling. In the in-depth interviews, the consumers talked openly about the fear of exposure that they are HIV infected. Thus, creating a "safe place" to allow the consumer to participate in the counseling is essential for some of the consumers to participate in counseling.

The most salient effect of the counseling is that it helps the consumers to begin to accept the fact that HIV -infected individuals are not automatically doomed to death and that others live with the HIV and they can also. Many of the consumers actually learn a new way of functioning as a group member rather as a individual. They also acquire a new support group and develop a trusting relationship with the counselor and their peers. The counseling helps the consumer to make the transition from living free of the virus and living with the virus. Through the counseling process, hope is restored.

The psychosocial aspect of the counseling is also important to creating a sense of belonging to an important social group and validation of self-worth at a time when the individual feels devalued. Besides the formal counseling, the informal activities provided for the HIV-infected person and their children provide a sense of community. In the in-depth interviews consumers discussed how the retreats, which are comparable to a weekend get away, made a difference in their lives. Often after the consumers have completed all phases of the intervention they continue to visit the CCHER office frequently. Site visits to the office by the evaluators confirm that one does not know who is a consumer and who is not. The atmosphere is warm and friendly and everyone is engaged in some type of activity. Some of the consumers volunteer in the office.

The evaluation revealed some disturbing news. The fact that less than half of the individuals who were eligible to participate in the program enrolled is an indication that there could be individuals who are not continuing their treatment or having their basic human needs met due to lack of follow-up case management. Even worse, there could be many uninformed HIV -infected individuals who are continuing to spread the disease. Another alarming finding was that 52 percent of the consumers did not know if their partners at the time they contacted HIV has been tested for the virus. Also, even though mu is not identified in this population, CCHER substance abuse data has uncovered that mu use is a problem in the Haitian community. This finding suggests the IUD identification has been under reported in



this study. Likewise, it is suspected that homosexuality is under reported in this study due to the fear of exposure. Homophobia cuts across all cultures, and it remains one of the most formidable barriers between HIV prevention programs and the consumers who need services.

The evaluation findings suggest that there is still a significant number of potential consumers outside of treatment. There is a need for a concentrated *HIV* education outreach campaign in the Haitian community. A general education campaign should be conducted in the Haitian community-at-large about the causes and transmission of *HIV*. Only through a massive educational campaign can the stigma associated with *HIV* / AIDS be eliminated. This could increase the number of persons who are willing to disclose their *HIV* status to new sexual partners. The most successful outreach is likely to be conducted by the peer leaders and the volunteer health educators.

Another important observation for future service planning is that the Haitian HIV -infected population is relatively poor. Only 21 percent reported wages as the primary source of income, 33 percent reported no sources of income and 33 percent receive SSI or support for dependent children; over 80 percent is between the ages of 30 and 59 years of age; 84 percent is dependent upon public payment for their health care. This means that public support for HIV -related health/medical care is essential. It also means that support services may be required over a longer period of time. The population is 59 percent female, which has implications for the types of support services that will be needed. The number of female clients also has implications for legal services.

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