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Subgroup/Office of Origin: National AIDS Policy Office

Series/Staff Member: Kristine Gebbie

Subseries:

OA/ID Number: 3771

FolderID:

Folder Title:
Meeting with Closing Plenary Session "Learning from the Past Focusing on the Future" 10/22/93

Stack:	Row:	Section:	Shelf:	Position:
S	66	5	4	3

Gladys Woman
FIGURES

[1638 Kirtwood
S.F. C.A 94124
641-5641]

get contact for Shelda's office

CITY AND COUNTY OF SAN FRANCISCO
DEPARTMENT OF PUBLIC HEALTH

JAMES LOYCE, JR., M.S., M.F.C.C.
ASSOCIATE DIRECTOR FOR ADMINISTRATION

AIDS OFFICE
25 VAN NESS AVENUE, SUITE 500
SAN FRANCISCO, CA 94102-6033

(415) 554-9111

NEW FUNDING PRIORITIES

Adopted by the Planning Council on October 18, 1993

SERVICE CATEGORY	***NEW PROJECTS/ PRIORITIES***
Primary Medical Care	*Expanded care for POC. *Taken to homeless or marginally housed, and to substance abusers. *At substance abuse detox sites. *Integrated women/ children primary care services.
Housing (Long-term)	*Subsidies, with general target of families, youth, POC. *For active users, with or without money management. *Emergency vouchers targeting families, active users, youth. *Congregate transitional housing for youth, with case management. *Housing information/ referral. *One-time housing grants (including for first/ last month rent, security deposits, moving expenses).
Food	*More food/ delivered meals. *Culturally appropriate. [May be done by voucher.]
Dental	*More dental, including bilingual Spanish services. Restorative and preventive.
Mental Health	*Long-term individual counseling for youth, POC, home-bound/ hospice, transgenders. *Short-term therapy (individual or group) for youth, POC, home-bound/ hospice, transgenders. *Psychological assessments as support to other services such as housing, case management; especially for Spanish-speaking and multiple-diagnosed clients. *Crisis intervention services (24-hour). *Medication monitoring.
Case Management	*Transitional services for incarcerated. *Money management with scope to housing. *General case management (brokerage) for homeless, IDUs, transgenders, youth, substance users. *Full spectrum with emphasis on starting early, with outreach.

SERVICE CATEGORY	***NEW PROJECTS/ PRIORITIES***
Substance Abuse	*Residential treatment specifically targeting POC, women with children, gay men, women (with sensitivity to Lesbians), sensitivy to sex workers. *Methadone maintenance. *Residential detox (including heroin, speed, crack). *Residential substance abuse treatment for mentally ill. *Encourage all programs to provide linkage to needle exchange programs.
Home Health	*Attendant care for persons with and without skilled nursing needs; including services in emergency housing sites. *More Home Health services, including Hospice
Client Advocacy	*Outreach to POC communities and linked to Case Management, with benefits counseling and legal services. *Print and electronic media outreach to POC, with special attention to Latino community. *Simplified service delivery directory, as tool for clients. *Treatment information and advocacy targeted to POC and those with low literacy.
Direct Emergency Assistance	*Vouchers to cover utilities, clothing, and critical personal needs.
Alternative Care	*Increase.
Buddy/Companion	*Emotional and psychological pe3r models, both individual and group, targeting youth and children (HIV+ or HIV-), clean and sober, heterosexuals, POC including monoloingual Spanish-speaking.
Hospice	*Enhanced residential hospice.
Rehabilitation	*Assistive or adaptive educational and rehabilitative devices and services (including vision services).
Day/Respite	*Adult day health. *Childcare, including emergency and respite care.
Transportation	*Taxi vouchers, general transportation vouchers, bus tokens: for transportation to medical care and to meet critical personal needs. [Encourage link to Medical Care and Case Management.]
Translation/Interpretation	*Translation linked to Case Management, Medical Care, and Client Advocacy.
Adoption/ Foster Care	*Child placement assistance, including Spanish-language capability.

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BAY AREA GAY NEWS

Kristine: Following are the major news topics raised in the last issue of the S.F. Sentinel and the Bay Area Reporter, B.A.R. This should give you a heads up on local Gay community concerns.

* Gov. Wilson vetoed AB 260 which allowed needle exchange programs. In his veto message Wilson indicated needle exchange would contradict the deterrence message of anti-drug programs. Wilson ignored the recent $400,000 CDC study showing the efficacy of needle exchange. Last year he cited the lack of any studies showing needle exchange to be effective as the basis for vetoing a similar bill.

* Gov. Wilson vetoed SB 670, by Tom Hayden. This bill would have required confidentiality measures for CD 4 t-cell tests the equivalent of those required for the HIV antibody test. Wilson said this would increase insurance costs. This is important because health insurance companies may be able to use a CD 4 test as a backdoor method to discriminate against people with HIV/AIDS.

* Gov. Wilson vetoed AB 736 which would have provided hospice care under the Medi-Cal program.

* Surgeon General Elders at a recent meeting said her relations with our office were excellent and that you were busy forging policy which she would support.

* In San Diego a highly publicized marijuana possession trial is underway. Sam Skipper a PWA is using the defense of medical necessity for growing marijuana for personal use in his backyard.

* It is reported that NIH is expanding its AIDS vaccine trials.

* Proposition 174. This is the voucher for schools initiative discussed in the cabinet meeting we attended. The Gay community is against it because it will fund religious right schools. This is a good opportunity for you to speak on a local issue and be in tune with the Administration.

* It is reported that the House has approved AIDS funding at a record level.

Prepared by Lance Alworth

Learning from the Past —

In research —
Community involvement
breadth & depth

In service —
protect Ryan White while doing reform
prepared/gender practitioners for the spread

In prevention —
community ownership

Wrapped around it all
"ATTITUDE"

Open talk - sexuality

Fed'l employees initiative

PSA's —

HIV NATIONAL AIDS UPDATE CONFERENCE SAN FRANCISCO

For Immediate Release
September 30, 1993

Contact: Wendy Ho Iwata
Phone: (415) 554-2556

SIXTH NATIONAL AIDS UPDATE CONFERENCE REFLECTS ON PAST, LOOKS TO FUTURE – OCTOBER 19 - 23, 1993, IN SAN FRANCISCO

Looking ahead to national healthcare reform with the hind-sight gained from twelve historic years of grappling with the AIDS epidemic, the nation's largest gathering of HIV/AIDS healthcare providers will meet for the sixth year in San Francisco for the *National AIDS Update Conference.* The theme of the *Sixth Annual National AIDS Update Conference* (*NAUC*) is *"Learning from the Past, Focusing on the Future,"* and will reflect the changing nature of HIV and AIDS-related care, as well as overall changes in healthcare as a result of the continuing epidemic. This year's Conference runs from October 19 through 23, at the San Francisco Civic Auditorium.

Confirmed speakers for the *AIDS Update Conference* include: **Kristine Gebbie** (the nation's AIDS Policy Coordinator), **Jeanne White** (President and Founder of the Ryan White Foundation), **Paul Volberding,** MD (UCSF Professor, Director AIDS Program at San Francisco General Hospital), **Donald Francis,** MD (HIV/AIDS Consultant), **Mark Smith,** MD (Member of the National Task Force for Healthcare Reform), **Don DesJarlais,** PhD (Research Director, Beth Israel Medical Center, Chemical Dependency Institute, New York), **Marilyn Chow,** DSc, RN (President and CEO, National League for Health Care), and **Mervyn F. Silverman** (President, American Foundation for AIDS Research).

The *NAUC* will be chaired by **Raymond J. Baxter,** PhD, former Director of the San Francisco Department of Public Health, and **Mary Pittman,** DrPh, President and CEO for The Hospital Research and Education Trust, Affiliate of the American Hospital Association. There will be ten plenary presentations, over 100 workshop sessions and ten optional intensive workshop sessions covering a variety of HIV-related issues. The Conference program also features an AIDS in the arts festival, performing arts theater, film festival, over 100 exhibits, roundtable discussions on a variety of topics, poster sessions, and formal receptions and other social networking opportunities.

The Conference includes five educational tracks: Policy and Administration, Prevention and Education, Care and Services, Treatment, Health Services/Program Evaluation. The program was selected from a broad range of subject areas developed by a national planning committee, and features such topics as:

- Behavior and Relapse Education: Media Hype or Reality?;
- Treating Pediatric HIV;
- Gay Men: Issues for the Second Decade;
- The AIDS Health Services Program: Final Evaluation;
- Tuberculosis and HIV;
- Learning from AIDS: Cost Financing and Healthcare Reform.

The Conference is co-sponsored by a unique consortium of over 30 national and regional organizations including professional organizations, healthcare associations, private and public health service providers, community-based and government agencies, and others. Participating in the *Sixth Annual National AIDS Update Conference* will be a broad range of healthcare providers, elected and non-elected community leaders, state and local government representatives, individuals with HIV infection, policy-makers and others concerned with the prevention and management of HIV infection. For general information, registration and exhibits, contact **KREBS Convention Management Services,** 555 DeHaro Street, Suite 200, San Francisco, CA 94107-2348, phone: (415) 255-1297, Fax: (415) 255-8496. For media or public relations information, contact Wendy Ho Iwata, Conference Media Relations Director at the **San Francisco Department of Public Health,** phone (415) 554-2556.

SAN FRANCISCO AIDS FOUNDATION P.O. BOX 426182, SAN FRANCISCO, CALIFORNIA 94142-6182

MEETING AGENDA

Kristine Gebbie,
National AIDS Policy Coordinator
Friday, October 22nd, 8:30-9:40 a.m.

Facilitators: Paul Di Donato and Patricia Dunn

1.	Ryan White CARE Act -Appropriations -Reauthorization **-Jerry Windley and Mike Shriver**	8:30-8:35
2.	Drug Treatment Funding **-Gene Copello**	8:35-8:36
3.	Health Care Reform **-Paul Di Donato**	8:36-8:45
4.	Prevention Reform **-Jim Kahn, Kerrington Osborne, Mike Shriver, Tom Coates, Sharen Trammel, Pat Franks**	8:45-8:55
5.	Needle Exchange **-Jim Kahn and Geoffrey Sackett**	8:55-9:00
6.	Housing **-Bob Nelson**	9:00-9:05
7.	Immigrants **-Tomás Fabregás**	9:05-9:10
8.	FDA Regs/Women and Clinical Trials **-Rebecca Dennison**	9:10-9:12
9.	Standby Guardianship **-Rebecca Dennison**	9:12-9:14
10.	Poppers **-Hank Wilson**	9:14-9:16
11.	Research and Treatment Development **-Anne Donnelly and David Lewis**	9:16-9:21
12.	Other e.g., Concerns Related to Specific Populations	9:21-9:40

25 VAN NESS AVENUE, SUITE 660 / 1170 MARKET STREET, 5TH FLOOR
SAN FRANCISCO, CALIFORNIA 94102
(415) 864-5855

SSI earned income allowance ($600)
$75/mo raise?
Episodic diseases & SSI — how to educate?
Social Security SSI state management?

HUD - Section 8 / HIV relationship?

Terry —
Youth housing 18-22?
SSI permanent

Clinton Library Transfer Form

Case #, if applicable	2018-0756-F	**Accession #**			
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Subgroup/Office of Origin	National AIDS Policy Office	**Subseries**			
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NATIONAL AIDS POLICY OFFICE
OFFICE OF THE COORDINATOR

ROUTING SLIP

DATE: 11/4

TO: John

FROM: ✓ W. STEVE LEE

____ For your information

✓ For your action other letters are drafted

____ Review and comment by (date) ____

✓ Prepare reply for Coordinator's signature

____ Reply directly and blind copy Coordinator

____ **Circulate/**forward to: ____

____ File

COMMENTS: Thanks.

for the cards / address in the folder

THE WHITE HOUSE
WASHINGTON

You should have a separate draft for the organizers

Dear ____

Thank you for participating in the meeting in Los Angeles on Tuesday evening, Oct ~~—~~.

I appreciated the opportunity to meet some of those working on HIV/AIDS issues in L.A. Please stay in touch as issues, concerns or opportunities arise.

Sincerely

The Materials You Requested Are Enclosed

Centers for Disease Control

National AIDS Information and Education Program

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service
Centers for Disease Control
Atlanta, Georgia 30333

CDC
CENTERS FOR DISEASE CONTROL

Hi Retina -

Following are some addresses of people who attended meetings with KG during her October 1993 visit to the L.A./San Fran area and John thought they should be added to the Chron. file. Letters have all been sent.

Thanks!

Amy☺

STEVE LEW
GAPA COMMUNITY HIV PROJECT.
1841 MARKET ST.
S.F. CA. 94102

Robert W. Howard
S.F. Network of Mental Health Clients, Inc.
405 Valencia St #316
SF CA 94110 415-861-3817

David D. Lewis 415-558-8669
Project Inform
1965 Market St., Suite 220
SF, CA 94103

Don Angus
Board, Project Open Hand
362 Collingwood
SF CA 94114

Sharen Trammell
Alameda County AIDS Advisory Board
499 5th Street
Oakland, CA 94607

TOMÁS FÁBREGAS
378 VAN BUREN AVE #501
OAKLOND, CA 94610
PHONE & FAX: (510) 451-4438

AFFILIATIONS: HEALING ALTERNATIVES FOUNDATION; ACT UP/IMMIGRATION WORKING GROUP - HIV PREVENTION PROJECT; SAN FRANCISCO AIDS FOUNDATION
EMAIL ADDRESS: 72714.2347@compuserve.com

Frederick Hobson
381 Turk Street #304
San Francisco 94102

MARIO R. NAVARRO
1049 Market St #200
SF. CA 94103

Jeffrey H. Kim
1049 Market St #200
SF CA 94103

Rex Palmer
484 Belvedere Ave
SF CA 94117

Elena N. Monteg
220 Precita St #4
San Francisco, Ca. 94117

Rebecca Denison
W.O.R.L.D.
POB 11535
Oakland CA 94611
510-658-6930
Fax: 510-601-9746

Doris Butler
World Insitute on Disability
510 16th Street
Oakland
510 763-4100 Fax 4109

Rachel Majors - (Transgender)
641 O'Farrel #310
San Francisco, CA. 94109
(415) 775-8452

Terrance Jourdan
641 Ofarrel #409
San Francisco Ca 94109

Deborah Reina
San Francisco AIDS Foundation/WORLD
2885 Bryant St
SF, CA 94110
415-282-9803

Randy Adkins
1760 Chester Dr
Pittsburg Ca 94565

(4)

Robert Baldock
San Francisco AIDS Foundation
1170 Market Street, 5th Floor
SF, CA 94102

V. "Buzz" Rademaker
1720 Lexington Ave
San Mateo CA 94402

David S. Johnson
Box 0886
SF, CA 94143-0886

Steve Byrne
c/o San Francisco AIDS Foundation
P.O. Box 426182
SF, CA 94142-6182

Rafiki
c/o 1638 Kirkwood
SF, CA. 94124

Teresa Crespo (REP: W.O.R.L.D. + BAY +'s)
158 Farnum St.
SF CA 94131

Edward Perkins
Rafika
1638 Kirkwood
S.F CAL. 94124

Gladys Figueroa
Rafika
1638 Kirkwood
S.F. CA 94124

Jim LEES
Coordinator, HIV Support Services
Larkin Street Youth Center
1044 Larkin Street
S. F, Ca 94109

SEP 27 1993

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

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SANTA BARBARA • SANTA CRUZ

SCHOOL OF MEDICINE

Please address reply to undersigned at
AIDS PROGRAM
San Francisco General Hospital
Building 80, Ward 84
1001 Potrero Avenue
San Francisco, CA 94110

I'd like to try & see him for a half hour or so while I'm in SF —

22 September 1993

Christina Gebbie, R.N.
National AIDS Policy Coordinator
750-17th Street, N.W., Suite 1060
Washington, DC 20503

Dear Ms. Gebbie:

Congratulations, first of all, on your appointment to the AIDS Policy Office. As I was asked to submit my own CV for the position, I gave enough thought to the job to follow your appointment quite closely. You seem to be off to an excellent start and I would assume that the appointment of Jocelyn Elders as Surgeon General should make it even more possible to accomplish something, finally in the field of HIV prevention. I assume that we will have an opportunity to cross paths at some point or another, perhaps at the Institute of Medicine, where I continue to be involved in the AIDS Drug and Vaccine Development Roundtable.

Again, belated congratulations on your appointment. I wish you all possible success in your position.

Sincerely,

Paul A. Volberding, M.D.
Professor of Medicine, UCSF
Director, AIDS Program, SFGH

PAV:CR

415/476-
~~0828~~
4082
X84232

Meet at APHA

DEPARTMENT OF HEALTH & HUMAN SERVICES

REGION IX
PUBLIC HEALTH SERVICE

MEMORANDUM

BA-fyi — Peter — thus note needs to get on my Oct schedule —

Date: SEP 2 1993

From: Regional Health Administrator
Region IX

Subject: Regional AIDS Coordinators

To: National AIDS Policy Coordinator

Thank you for advising me of your decision not to support the PHS Regional AIDS Coordinators (RACs). I regret that when you called me my schedule did not allow time to talk with you at greater length. I would like to share some of my thoughts about future relationships between your office and the PHS Regional Offices.

Given your mission and the PHS program focus of our RACS, I can understand your decision not to support them. However, without PHS support to continue the functions, the agencies and individuals we serve may perceive a decrease in current Federal interest and support for their efforts.

Over the years, the RACs have demonstrated an exceptional capability for providing information about the efforts of agencies and individuals in fighting the epidemic and in convening community AIDS leaders for consensus building. I believe these functions would provide your office with an independent, community-linked perspective with which to balance the central focus your other staff can provide.

I look forward to meeting with you when you visit San Francisco in October for the National AIDS Update and APHA Conference. I hope to enlist your support to gain resources within PHS dedicated to continuing an amended RAC function. I am happy to have the opportunity to work with you again.

John D. Whitney
Regional Health Administrator

415/556 5810

Jeannie A. Brewer, M.D.

NOV - 2 1993

October 28, 1993

Kristine Gebbie, RN, MN
National AIDS Policy Coordinator
Executive Office of the President
Washington DC 20500

Dear Ms. Gebbie:

It was such a pleasure to meet you at AIDS Project Los Angeles yesterday with the Neighborhood Network group. I was quite impressed with your candid, forthright answers to what are very difficult questions. You strike me as a dedicated, highly intelligent and compassionate individual and I feel we are lucky to have you working on these issues.

You have my full support as you continue to work on the areas of maintaining adequate funding for The Ryan White CARE Act, education and continuing education of primary care physicians, needle exchange programs, and providing access to quality care for HIV infected individuals.

If there is anything I can do to assist your efforts, please let me know.

Sincerely,

Jeannie A. Brewer

2671 Laurel Pass Los Angeles California 90046 phone: 213.848.9368 fax: 213.656.3566

PHOTOCOPY
PRESERVATION

Ron Rowell, MPH
Executive Director

THE NATIONAL NATIVE AMERICAN
AIDS PREVENTION CENTER

3515 Grand Avenue, Suite 100
Oakland, California 94610
(510) 444-2051
FAX (510) 444-1593

THE NATIONAL NATIVE AMERICAN AIDS PREVENTION CENTER

The National Native American AIDS Prevention Center's mission is to stop the spread of HIV and related diseases, including sexually transmitted diseases and tuberculosis, among American Indians and Alaska Natives by improving their health status through empowerment and self determination. Our role is to serve as a resource to Native communities and to support community efforts by providing education and information services, thereby enhancing the physical, spiritual, and economic health of Native people.

For more information contact

THE NATIONAL NATIVE AMERICAN AIDS PREVENTION CENTER

Main Office
3515 Grand Avenue, Suite 100
Oakland, CA 94610
(510) 444-2051
(510) 444-1593 FAX

Division of Client Services
205 West 8th Street, Suite 103
Lawrence, KS 66044
(913) 865-4297
(913) 842-0145 FAX

National Indian AIDS Media Consortium
1433 E. Franklin Avenue, Suite 3A
Minneapolis, MN 55404
(612) 872-8860
(612) 872-8864 FAX

Ahalaya HIV Case Management Project
1200 N. Walker, Suite 605
Oklahoma City, OK 73103-3743
(405) 235-3701
(405) 235-1801 FAX

La Frontera Center Case Management Project
502 West 29th Street
Tucson, AZ 85713-3394
(602) 770-7418
(602) 770-7419 FAX

The National Native American AIDS Prevention Center (NNAAPC) is a 501(c)3 non-profit corporation governed by an entirely Native American Board of Directors including people with HIV, tribal officials, public health professionals, health care providers, and substance abuse program administrators. The organization was founded in 1987 as a network of concerned Native people willing to speak publicly on the need for HIV prevention education by and for Native Americans.

In August 1988, the organization was awarded a five-year contract from Centers for Disease Control (CDC) to:

- Conduct outreach to Native organizations & communities
- Train community-based HIV educators
- Provide technical assistance in community organizing
- Operate a national toll-free Indian AIDS Information Line: 1-800-283-2437
- Operate a national clearinghouse for Indian-specific AIDS information
- Provide ongoing information services, including *Seasons*
- Develop curricula for target populations

In January 1989, the agency was awarded a second five-year grant from the CDC to organize a National Indian AIDS Media Consortium of Native-owned newspapers, radio stations and television programs. Quarterly press packets are sent to members with statistics, articles on Natives and AIDS, and occasional ad slicks and public service announcements for publication or broadcast. During the second year of this grant, the agency organized the National Native Community AIDS Network. NNAAPC provides community-based organizations with monthly reports on research, statistics, funding opportunities, and other community-based efforts. There are more than 150 members of the network.

In 1991, NNAAPC was awarded a grant through the Health Services and Resources Administration (HRSA) to operate community-based demonstration programs in Oklahoma City and Tucson, Arizona. These programs offer case management and client advocacy services to Native Americans with HIV infection. Working in collaboration with a range of local service providers the programs maximize access to medical, psychosocial, and practical support services.

Please add my name to your mailing list to receive your newsletter SEASONS.

Name _____

Agency _____

Address _____

Phone _____

The National Native American
AIDS Prevention Center
3515 Grand Avenue, Suite 100
Oakland, CA 94610

THE NATIONAL
NATIVE AMERICAN
AIDS PREVENTION
CENTER

THE NATIONAL NATIVE AMERICAN AIDS PREVENTION CENTER

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Please add my name to your mailing list to receive your newsletter SEASONS.

Name _____

Agency _____

Address _____

Phone _____

The National Native American
AIDS Prevention Center
3515 Grand Avenue, Suite 100
Oakland, CA 94610

THE NATIONAL
NATIVE AMERICAN
AIDS PREVENTION
CENTER

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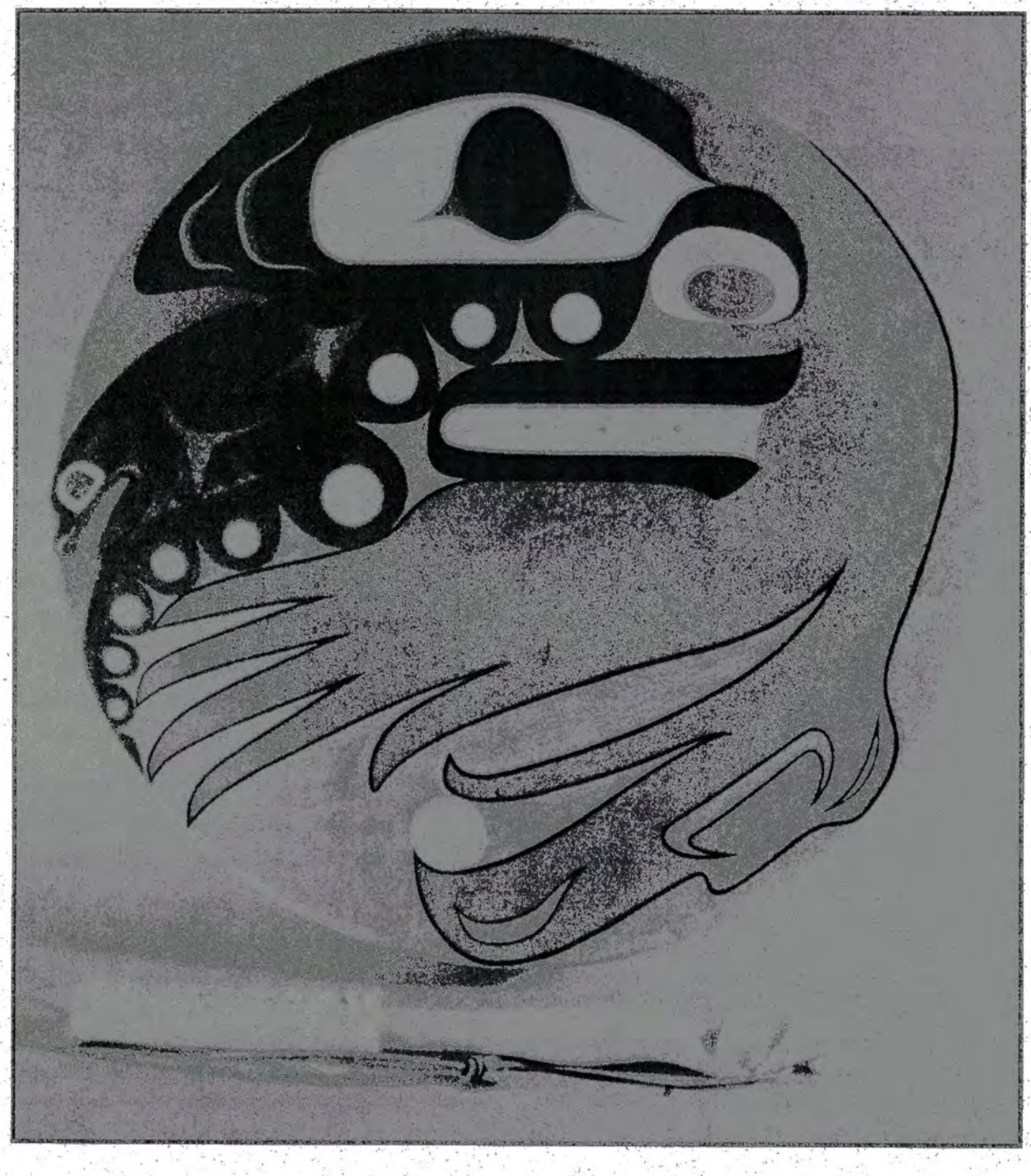
SEASONS

THE NATIONAL NATIVE AMERICAN AIDS PREVENTION CENTER

AUTUMN 1992
QUARTERLY



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THE NATIONAL NATIVE AMERICAN AIDS PREVENTION CENTER

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LESSONS LEARNED
NATIONAL NATIVE AMERICAN AIDS PREVENTION CENTER
1988 - 1993

Prepared By

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Title of Project: NATIONAL NATIVE AMERICAN AIDS PREVENTION CENTER
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STATEMENT OF PUBLIC HEALTH PROBLEMS

Native American communities face a myriad of public health problems. Many of them are preventable. The health status of Native Americans is lower on every indicator than the rest of the population. Thirty seven percent of all Native Americans die before the age of forty-five of preventable causes. Among the ten leading causes of death the majority are directly or indirectly related to substance abuse.

There have been diagnosed AIDS cases in our population since before 1984. There is also evidence of on-going high-risk behavior. The sexually-transmitted disease rate among Native Americans is twice as high on average as for the non-Native population; in some states it is significantly higher. The teen pregnancy rate averages between 20%-25% of all births. In the military seroprevalence study, Native American recruits had the third highest rate of HIV infection nationally. In a recent CDC-IHS seroprevalence study, rural pregnant Native women in their third trimester had a four to eight times higher HIV infection rate than for other rural women in similar studies.

Native Americans are generally less educated than the population as a whole. Although half of all Native Americans are urban dwellers, roughly half live in rural and reservation areas. More Native Americans live in poverty than do other Americans. The extended family and clan relationships are still part of the everyday lives of many Native Americans. There are traditional roles for Two-Spirit (gay and lesbian) people in many of the First Nations. While our poverty, poor health and lack of formal education can often create barriers, the extended family and community relationships as well as traditional teachings can be a profound resource in the fight to prevent the spread of HIV in our population.

The National Native American AIDS Prevention Center was founded to conduct outreach, provide training, technical assistance and access to information for Native American communities throughout the United States and to build a network of support for locally-based efforts. At the time of its foundation and later when it was funded, there were many gaps. There were no national Indian organizations willing to take a leadership role in organizing communities for HIV/AIDS prevention. There was a lack of coordination and cooperation between Indian organizations on the issue of HIV/AIDS. There were only a handful of locally-based Native-focused HIV prevention programs and only 16 Native and non-Native agencies with HIV-related programs in all which had any component targeted to Native people. There were virtually no educational materials on HIV/AIDS directed to Native people. No technical assistance was available to those wanting to do HIV prevention in Indian Country and there was no culturally-specific training in this area. There had been no real effort to address issues of sexuality and health within a cultural context. Most Native communities were isolated from the major sources of HIV-related information in the cities. There was a lack of awareness in general of the threat of HIV to Native communities and the relationship of other major health problems to the spread of HIV. In 1988 there was very little data to indicate the magnitude of the problem other than reported diagnosed AIDS cases and the results from the military seroprevalence study.

STATEMENT OF ORIGINAL PLAN

NNAAPC has from the beginning viewed its role as a national organization to be a facilitator and enabler for work which must take place at the community level. The original objectives and workplan of the organization were divided into these three main areas: 1.) Training; 2.) Technical Assistance; and 3.) Information Services. These categories of service did not change over subsequent years. The original proposal contained objectives related to the development of KAB baseline surveys which were done but were never followed-up for reasons related to validity and practicality. The original proposal also contained an objective to set-up an on-line bulletin board for IHS and other Indian health care providers to improve the ability of those seeing the epidemic on the front-lines to share information with one another. Although it seemed a good idea at the time, it was abandoned when we discovered how few providers at the time had access to computers. Had we done a more thorough needs assessment in this area, we would have discovered that fact.

The training activities were originally focused on "AIDS 101" content. It became apparent to us within the first year of the project that this was not a good use of our limited resources. Since a "training of trainers" (TOT) program had been and remained part of the overall program design, we decided that basic AIDS education should be left to those who we could train and that we would focus on TOT and specialized issues. Nevertheless, it took some time before there was a large enough pool of people who could do this kind of education at the local level. There were also some Native people being trained through state-funded programs and the Red Cross who could offer this kind of basic education.

Our training of trainers also evolved through the years. While it began as a two-day session with a narrow range of topics, by the end of 1990 it had become a week-long meeting covering a multitude of topics including specific target population considerations, epidemiological information, applying traditional Native cultural methods and ideas, STDs, tuberculosis, staff burn-out, and others. Most of the changes came about through participant evaluations and recommendations. Our vision of the purpose of the training has also shifted over time from one of training "trainers" to one of training "community organizers" with a wider range of skills.

Technical assistance was originally designed to follow a modified PATCH (Planned Approach to Community Health) program. However, we discovered that the demand for technical assistance covered a broader range of activities than we originally envisioned. These included not only community organizing and planning but advocating with funders, writing and editing proposals, designing data collection systems, overcoming tribal government and church resistance, doing background legal research and assisting with evaluation activities.

Information services included the publication of our quarterly journal "Seasons;" collecting, reviewing and cataloguing all existing Native-targeted HIV educational materials; developing handbooks, curricula and reference materials; and operating a toll-free National Indian AIDSLINE. Designing and publishing handbooks and curricula was a later development of the information services division and occurred as a result of ongoing gaps in culturally-specific information available for Native communities.

In 1990 we surveyed 250 and in 1993, 496 Native individuals working at the community level in HIV prevention to obtain feedback on our program design, outcomes and our clients' future needs. The feedback from those surveys verified that our clients believe our basic program design meets their needs.

STATEMENT OF PROCESS/OUTCOME EVALUATION RESULTS

Overall outcome: The most significant outcome we were able to measure was that seven out of ten of the 150 respondents to our survey of those working in HIV prevention in Indian Country in 1990 said that *NNAAPC had played a significant role in the initiation of their community's HIV prevention activities.* (40% of those surveyed responded.) This was true of both rural/reservation and urban programs. The 10-12 individuals working on HIV prevention in Native communities at the start of our program in 1988 grew to almost 500 by the start of 1993. Ninety-five percent of survey respondents in 1993 stated that NNAAPC had contributed to raising the awareness of Native health educators about HIV. While Native people were scarcely a consideration at the beginning of the national people of color AIDS effort at CDC, NNAAPC's efforts to educate and insure the participation of Native people at all levels of planning and decision-making has made Native Americans a permanent part of the broader people of color coalition. NNAAPC is the first national Native health program in U.S. history ever funded entirely outside the traditional Indian bureaucracy. This has allowed new types of networks to develop, opening up new sources of support for Native community health initiatives which did not exist before.

Training: Our nine training of HIV educators/organizers sessions trained 241 individuals from August, 1988 through December, 1992. Of these,

- 75% were female and 25% male
- 32% were nurses or health educators
- 22% were tribal community health representatives (CHR's) and case managers
- 14% were substance abuse counselors
- 32% were divided fairly evenly between STD/AIDS coordinators, administrators, planners and others
- 37% worked in tribal health departments
- 19% worked in urban Indian clinics
- 11% worked in other tribal departments
- 33% worked in other settings, e.g., education, non-Indian CBOs, IHS and other urban Indian programs

Every region of the United States plus participants from Canada have been represented in these trainings. The top ten states represented in these trainings were:

Arizona (35) Michigan (24) Washington (22) California (19) New Mexico (18) Oklahoma (15) Michigan (15) Nevada (15) Wisconsin (15) Montana (10).

Trainings are held regionally and have occurred in California, the Northwest, Northeast, Southeast, Upper Midwest, Southwest, Great Basin and Southern Plains. In six-month follow-up surveys of those who went through the training from 1988 to 1990 we found that 87% had conducted 692 community-based education sessions reaching 8,297 people. The follow-up data for TOT's in 1991-92 is not yet available. We estimate that these figures will roughly double.

In addition to our regional training of HIV organizers/educators, we also conducted 126 other training events on various HIV-related topics to 10,320 people in 27 states and Canada. Seventy seven (61 %) of these events were for rural/reservation populations, 36 (29%) were for urban people and 13 (10%) were mixed urban and rural. Of these trainings:

- 46% were basic AIDS training
- 18% were on cultural issues related to HIV/AIDS

- 13% were other HIV/AIDS-related issues
- 9% were on HIV/AIDS policy development
- 8% were on substance abuse & HIV
- 5% were on sexuality & HIV
- 2% were on antibody testing

Of the 126 agencies and organizations receiving this additional training:

- 37% were tribal agencies
- 18% were Indian Health Service programs
- 12% were non-Indian agencies
- 10% were government agencies (other than IHS)
- 6% were urban Indian agencies
- 6% were educational institutions
- 6% were other Native organizations
- 3% were substance abuse programs
- 2% were correctional institutions

Technical Assistance: Technical assistance was provided on 44 occasions to 35 agencies and communities from August, 1988 through December, 1992. Of these, 34 were Native and 1 was non-Native. The following areas were covered by technical assistance activities:

- Developing a community AIDS task force
- Assisting with funding proposals
- Assisting with developing community HIV prevention plans
- Developing HIV/AIDS policies
- Evaluating HIV prevention activities
- Helping with developing information modules
- Facilitating community meetings
- Acting as an inter-agency intermediary to improve local cooperation
- Designing a community needs assessment
- Developing case management services for HIV infected individuals
- Researching legal issues for county funding of a reservation HIV program
- Researching and providing behavior change articles from professional literature
- Developing targeted gay male needs assessments
- Developing a curriculum on traditional teachings related to gender roles and sexuality
- Planning for content of HIV/AIDS training in a local Native language
- Conference planning
- Providing background research on street outreach to substance abusers
- Assisting with Indian Child Welfare Act HIV activities for youth
- Designing a surrogate marker data collection system
- Assisting traditional healers to understand what Western thoughts are on HIV/AIDS

Technical assistance was provided to the following types of organizations:

- Reservation communities - 12 (34%)
- Urban Indian clinics - 9 (26%)
- Regional Indian health organizations - 6 (17%)
- Non-reservation tribal health departments - 5 (14%)
- AI/AN AIDS service organizations - 1(3%)
- Indian Health Service - 1 (3%)

- Non-Native organizations - 1 (3%)

Technical assistance was provided in 14 states (Alaska, Arizona, California, Hawaii, Maine, Michigan, Minnesota, Montana, New Mexico, New York, Oklahoma, Oregon, Washington and Wisconsin) and the District of Columbia.

A special handbook for tribal governments and organizations on the development of HIV/AIDS policies was developed in 1991 in a collaborative project with the Shakopee Mdewakanton Sioux Tribe in Minnesota. These policies were submitted to the National Congress of American Indians (NCAI) at their next annual meeting for endorsement. Using Ford Foundation funds through George Washington University, NCAI bound these policies and distributed them to every tribal leader who was a member of NCAI. NNAAPC also drafted a handbook of HIV/AIDS related policies for Indian Child Welfare Agency programs. We are unclear how many tribes may have actually adopted these or similar policies, but we are aware of only three.

Information Services: Information services has four major focus areas: 1.) The National Indian AIDSLINE toll-free number; 2.) Materials collection and dissemination / clearinghouse activity; 3.) Materials development and 4.) "Seasons," our quarterly journal.

The National Indian AIDSLINE began operation in January 1989. Through March, 1993 it has fielded 2,071 calls. Calls have come from every state except Tennessee, South Carolina, Delaware and West Virginia.

- 54% of the calls were from Native Americans
- 30% were from non-Natives and 16% were unknown
- 60% of callers were female, 40% male
- 30% were health and human services providers
- 20% were general public
- 15% were education/government staff
- 15% were community based organizations
- 6% were gay/bisexual
- 4% referred to themselves as high risk
- 4% were HIV+/PWA
- 6% were other

Among the calls:

- 44% were for general AIDS information
- 23% were inquiries about NNAAPC services
- 14% were for risk reduction and antibody testing information
- 11% were for current statistics
- 8% were to discuss grief/loss, symptoms/treatment or sexuality concerns.

Referrals of callers to other services from the AIDSLINE included:

- 50% to NNAAPC's clearinghouse
- 17% to other agencies for materials
- 11% to medical, social or professional services
- 4% to NNAAPC's education division
- 4% to antibody test sites
- 15% to other services or organizations.

Thirty nine percent of the callers originally learned of the National Indian AIDSLINE from materials (posters, brochures, etc.) they had picked up or seen. Thirty one percent had been referred by a health, social services or educational professional. Ten percent were made aware through the media, 8% from NNAAPC staff, 4% from family and friends and 8% from other sources.

Clearinghouse activity - Two thousand three hundred four requests (2,304) for materials had been placed between December 1988 and December 1992. Of these

- 53% were by Native Americans, 47% non-Natives
- 53% were from rural/reservation communities, 47% urban
- 29% of requests were from individuals
- 14% were from community-based organizations
- 13% educational institutions
- 11% clinics & health centers
- 9% government agencies
- 7% tribal governments
- 6% Indian Health Service hospitals and 8% other

Of those making requests:

- 48% requested the standard "information packet" which included "Seasons," Raven's Guide, resource catalogue, reprints, agency brochure and subscription order form
- 13% asked to be added to the "Seasons" mailing list
- 11% wanted to receive the resource catalogue
- 9% requested graphs of the latest Native AIDS statistics
- 8% requested specific HIV/AIDS information
- 2% wanted the guide for developing tribal HIV/AIDS policies
- 1% requested the Native HIV/AIDS speakers directory
- 3% wanted other information

Materials were requested from every state with the exception of Alabama, Mississippi, Vermont and West Virginia. The ten largest volume requests by state in ranked order were California, Arizona, New York, Washington, New Mexico, Oklahoma, Texas, South Dakota, North Dakota and Michigan.

Materials development - In addition to the materials from other sources that we include in our catalogue and review, we have developed materials on our own and in collaboration with other Native organizations. We published HIV Prevention in Native American Communities in 1992, a reference manual for Native HIV workers on the front lines which contains five sections: basic facts about HIV/AIDS, antibody testing and treatments; high risk behaviors and STDs; prevention education and training; target populations; and planning. This was a thorough revision and rewriting of an earlier manual developed by NNAAPC's Executive Director for the California Rural Indian Health Board. User response to the manual has been very positive. We also collaborated with the Alaska Native Health Board in the production and distribution of two videos with Native PWAs entitled "Circle of Warriors" and "Face to Face;" and the development of the "Raven's Guide," a catalogue of all available materials specific to Native Americans and HIV or STDs.

"Seasons" - From its first issue in 1988, "Seasons" has been *the* most culturally-specific publication on HIV/AIDS among Native Americans in the United States. It is also one of the most stunningly attractive publications in the AIDS field (the first issue was called "AIDS In Indian Country," and was not so attractive). Seventeen issues have been published. The mailing list of approximately 3,000 includes every tribe and Native village in the United States as well as non-Native agencies, state

health departments and Federal government agencies. Letters from readers confirm our opinion that we publish one of the best journals of its kind. Over the years, "Seasons" has focused on one main topic per issue including:

- #1 Models of HIV prevention
- #2 Materials development
- #3 Fear reactions to AIDS: rational & irrational
- #4 Stories of Native men & women with HIV/AIDS
- #5 Lessons of Kalaupapa, the Native Hawaiian leper colony
- #6 Behavior change: models of prevention
- #7 HIV prevention programs for Native youth
- #8 Community responses to HIV/AIDS
- #9 AIDS among Alaska Natives
- #10 "Coming Out" with HIV
- #11 Surviving with HIV
- #12 AIDS in the urban Native community
- #13 Traditional culture and HIV/AIDS
- #14 First reactions to HIV: self and family
- #15 The color of AIDS
- #16 Access to care
- #17 Tuberculosis and HIV

In addition, every issue generally includes a review of Native materials, announcements of grants and conferences, tips on HIV education and the latest statistics on diagnosed AIDS cases in our population.

STATEMENT OF LESSONS LEARNED

Overall impact

The most important outcome of the work of the National Native American AIDS Prevention Center is that ***its activities have resulted in a significant increase in HIV prevention activities in Native communities throughout the U.S.*** This is what our clients themselves have told us in two national surveys in 1990 and 1993, and what we have observed through our networking. Our clients unanimously view our program design (training, technical assistance, access to information) as meeting their needs. It is clear that our impact is not only a function of program design, but because we are a Native American organization which understands Native cultures and ways of viewing the world, providing us with access to communities non-Natives would not have. It is clear from the statistics cited above that we have done an enormous amount of work with relatively few resources. (It is sobering to realize that our national program is funded at less than a neighboring Native HIV prevention program which serves only one county.) This is the result of a clear mission, committed and skilled staff and sound business practice. We are also unafraid to learn from our mistakes.

Examples of limited impact

We recently initiated three year follow-up telephone interviews in three communities where we felt our targeted technical assistance had been of limited impact: the Penobscot and Pleasant Point Passamaquoddy reservations in Maine, and the Comanche Tribe in Oklahoma. We could not see ongoing HIV prevention activity and we wanted to know why in order to improve our effectiveness in the future. In the case of the Penobscot and Passamaquoddy in Maine, we discovered our assumptions were wrong. In fact, quite a bit of ongoing work was taking place and things are

continuing to progress very well from where they had been in 1989. The lesson here was that earlier follow-up would have kept us better informed. In the case of the Comanche Tribe-sponsored "Inter-Tribal AIDS Task Force" in Southwestern Oklahoma, education did continue for a while after our intervention, but it ceased after a year. The problems identified in the interview were: 1.) Significant turnover in each tribe's staff which represented a loss in "institutional memory;" 2.) Lack of success with obtaining funds from the State or CDC to support the effort; and 3.) A lack of shared responsibility among the tribes for the project: all the burden fell on one person in one tribal department. The informant suggested that more regular and ongoing contact would have been helpful between NNAAPC and the project, at least monthly or quarterly. She also suggested that more help with materials and improved availability of staff for on-site visits would have improved their ability to sustain the project. She also mentioned the importance of NNAAPC's moral support and hearing they were doing the right thing as a factor in the early success of the project.

Our tribal HIV policies manual and our collaboration with the National Congress of American Indians to distribute copies to all tribal leaders who are NCAI members - about half of all tribal leaders - and provide them with training at NCAI's annual meetings has not resulted in much success. There are still very few tribes which have taken the time to consider the potential impact of HIV/AIDS on their communities and to plan ahead. We are troubled by this lack of attention by tribal leaders to HIV/AIDS, but we feel it is indicative of a larger issue. Health is not high on the priority list of many tribal leaders for whom economic development and treaty rights take precedence; and HIV/AIDS is low on the priority list for those who do care about health. Getting their attention will take much more time than we had hoped. In the meantime, we must try to insure that they do not act as barriers to getting the work done at the community level.

Examples of significant impact

We have succeeded in motivating and enabling many individuals and groups within local Native communities to undertake HIV prevention activities, primarily within the context of existing agency/program structures. The information received from follow-up surveys of participants in our week-long regional HIV educator/organizer trainings and our 1990 and 1993 community AIDS network surveys support this conclusion. We have provided the necessary leadership and focus on AIDS which was so badly needed to get things moving. We have been able to frame the issue so that it is understandable within the context of many other serious social and economic issues with affect Native people.

A few specific examples include:

- Helping to overcome church resistance to HIV education on the Penobscot reservation and enabling church, educational, health and tribal employees to work together to insure ongoing HIV prevention education for youth. This occurred through NNAAPC staff facilitation of a community meeting of all interested parties.
- Helping a local agency obtain county funding for an on-reservation HIV prevention program near Tucson through testimony and background research on the legal status of Indian Country and the responsibilities of state and local government to on-reservation Indians. This enabled an HIV prevention program seeded with funds from the U.S. Conference of Mayors to continue.
- Developing a proposal for San Diego's urban Indian clinic for Ryan White funding to provide case management services for Indian people with AIDS. It was funded.
- Successfully creating a network of all those people working at the local level in HIV prevention in Native communities which keeps them informed, banishes isolation, and provides badly needed moral support and a cross-fertilization of ideas.
- NNAAPC staff have also added significantly to the literature concerning Native Americans and

HIV/AIDS through articles published on its work and findings in several journals and publications, including Drugs and Society, SIECUS Reports, Winds of Change, National Conference on Drug Abuse Research & Practice Highlights, HIV and Alcohol Impairment: Reducing Risks Conference Proceedings; and through abstracts accepted for both oral and poster presentation by the International AIDS Conferences in Montreal, Amsterdam and Berlin.

A few examples of partnerships and collaborations which have occurred as a result of NNAAPC's work include:

- *Alaska Native Health Board* - NNAAPC and ANHB jointly produced a resources catalogue and two videos to prevent unnecessary duplication of services and to take advantage of NNAAPC's national distribution system;
- *Indian Health Service AIDS Program* - NNAAPC has integrated IHS' national and area office AIDS coordinators into its national network, actively participated in their meetings and solicited their input;
- *U.S. Conference of Mayors* - NNAAPC staff provided technical assistance with USCM's research project on HIV prevention efforts among gay men of color and assisted with site development;
- *Minnesota American Indian AIDS Task Force* - NNAAPC has joined with MAIATF on many training, technical assistance and policy projects within the state of Minnesota;
- *National Congress of American Indians* - NNAAPC assisted NCAI with its regional and national HIV/AIDS tribal summit meetings by providing staff time, consultation and technical assistance as well as soliciting NCAI's assistance with adopting and distributing model tribal HIV/AIDS policies;
- *State of California Department of Health, Office of AIDS* - We have provided technical assistance to state grantees at the state's request and have participated as advisors in a reassessment of the state's HIV prevention program;
- *National Conference of State Legislatures* - NNAAPC provided technical assistance to NCSL to develop a national conference of Native American legislators on HIV and faculty for the annual meeting.

Conclusions and Recommendations

NNAAPC has succeeded because it is a Native-governed and staffed organization which provides a focus for HIV/AIDS prevention in Native American communities. Our model has been successful in motivating Native people to join us and in providing those so motivated with training, technical assistance, access to information and moral support. We have succeeded in creating a national network of community-based Native HIV educators and organizers. We have raised the level of awareness and knowledge among non-Natives of the cultural, health and socio-economic issues facing Native America. By doing so we have helped open up new resources for Native communities. The success of NNAAPC's model is due in large part to its respect for and recognition of the importance of having community-based people working to prevent HIV who are experts on their own communities. Much of what we do is to convince our people to believe in themselves and their abilities by asking the right questions and trusting our clients to figure out the answers. We refer to this approach as "self-determination for health." Since there is no clear-cut recipe for the kind of behavior change we seek we must look for the answers from within our own communities, their experiences, traditions and values.

People who know their own communities are more effective prevention advocates for those communities. We assumed this was true at the beginning and we are more convinced than ever after working in Native communities throughout the U.S. and Canada. Although it is sometimes important for Native people from outside the community to bring the message initially (it is common for community members to devalue their own messengers), any sustained effort will require the labor of those who understand who the local people are, how they speak, who they listen to and respect,

where they spend their time and what their values are.

Native people are more willing to pay attention to information provided by other Natives and will respond better to messages which are tailored for them. There is a long, sad history between Native Americans and the U.S. Native laypeople sometimes distrust information from or the intentions of non-Natives. Native Americans can often reach where non-Natives cannot. Native Americans seldom see themselves reflected in popular media other than as stereotypes so there is power in materials which reflect Native culture and sensibility. Culturally-specific materials get immediate attention.

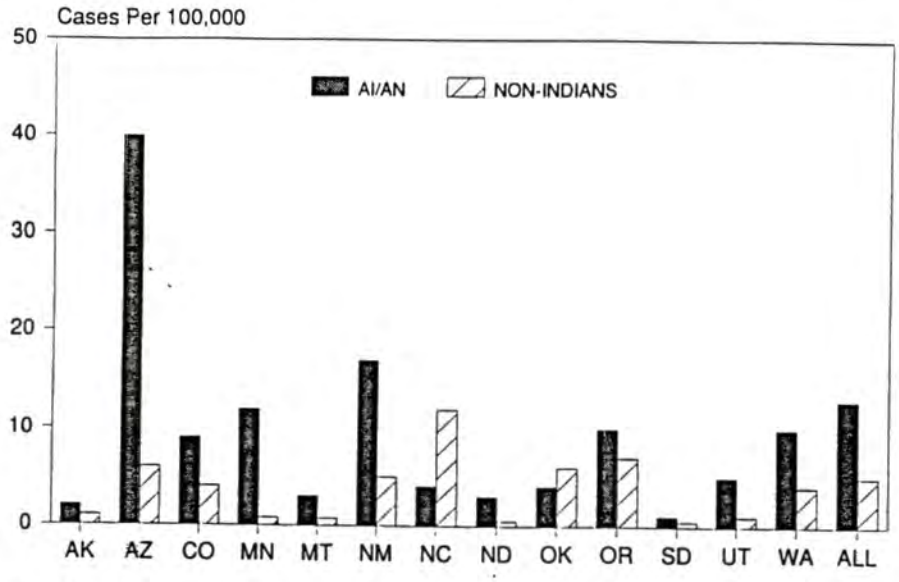
Relatively few people can accomplish a lot by building networks at all levels. It is not traditional for Native American communities to reach out to non-Native communities for support. The AIDS epidemic has begun to bring about change in these attitudes. People working in HIV prevention in Native communities have felt isolated and alone and have realized the importance of building support networks with others working in HIV within and without the larger Native American community. In some cases, it has only been by working in coalition with other communities of color that Native HIV prevention programs have had the clout to obtain resources to do the work. As a very small part of the overall U.S. population, our voices can go unheard without the support of others more numerous than ourselves.

Native communities are better able to understand the importance of HIV prevention when it is placed in the context of other common community health issues and of history. Because HIV/AIDS is often viewed by Native Americans as an exotic disease affecting primarily urban White gay male populations, it is important to frame HIV/AIDS in terms which bring it "home." By drawing connections between commonly recognized causes of morbidity and mortality in our population and HIV, we are able to illustrate how the growth of HIV infection is a direct consequence of the underlying behaviors at the root of our overall poor health. The death of millions of our ancestors and fellow tribespeople since 1492 was the result primarily of infectious disease epidemics resulting from contact with "Old World" pathogens. We have found that placing this new and profound demographic threat within its Native American historical context helps our people understand the importance of prevention and motivates action to protect future generations.

Preventing the spread of HIV is a long-term problem requiring long-term solutions. When we began our program, we were sanguine about the prospects for stopping HIV in its tracks among Native Americans. It appears oddly naive from this perspective that we did not appreciate the difficulty of changing substance abusing and risky sexual behavior. We didn't consider the possibility that new waves of youth in the prime of their sexual life would view HIV as a problem of the older generation. We also naively thought that education by itself would change behavior. What we learned is that this is a long-term, complex struggle. It will require changes in entire communities, not only individuals, if we are ever to succeed.

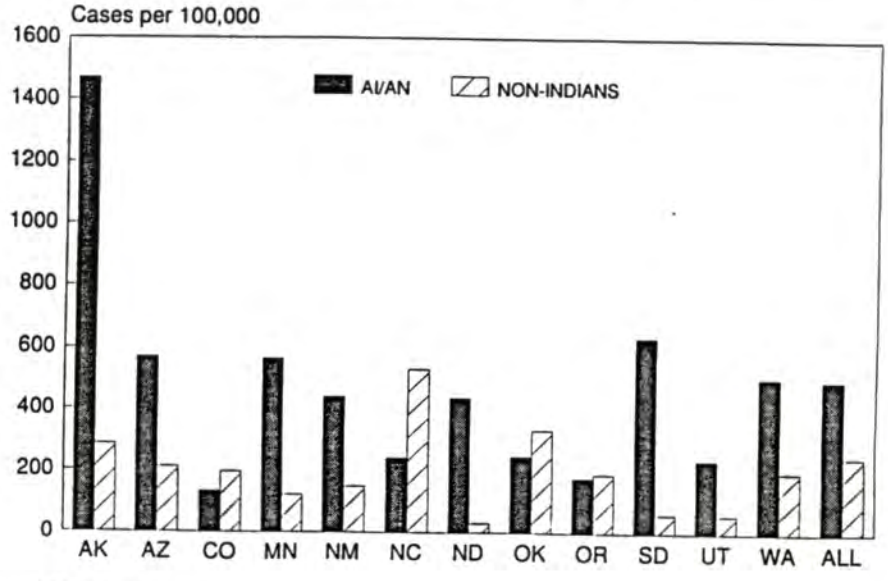
The journey we have undertaken at NNAAPC to prevent the further spread of HIV and related diseases among Native Americans will take much longer than we had originally anticipated. Behavior change of the scope we envision takes time and requires the continuous and combined efforts of many people. Though much has been accomplished, so much more remains undone. Given adequate resources and with our proven commitment to this urgent work we can continue to improve the health of Native Americans in collaboration with government, Native and non-Native organizations.

PRIMARY AND SECONDARY SYPHILIS
American Indian/AK Native vs. Non-Native



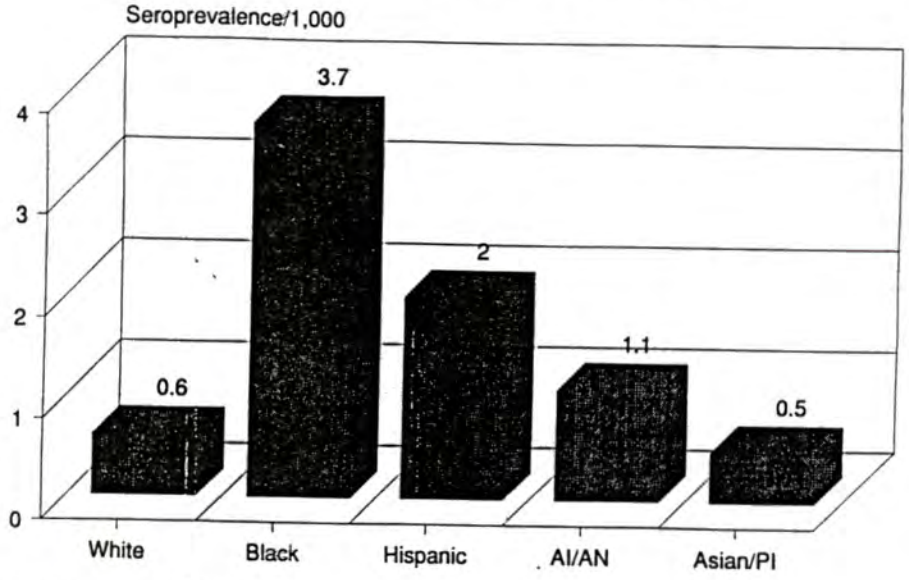
Source: CDC 1984-88

GONORRHEA CASE RATES
American Indian/AK Native vs. Non-Native



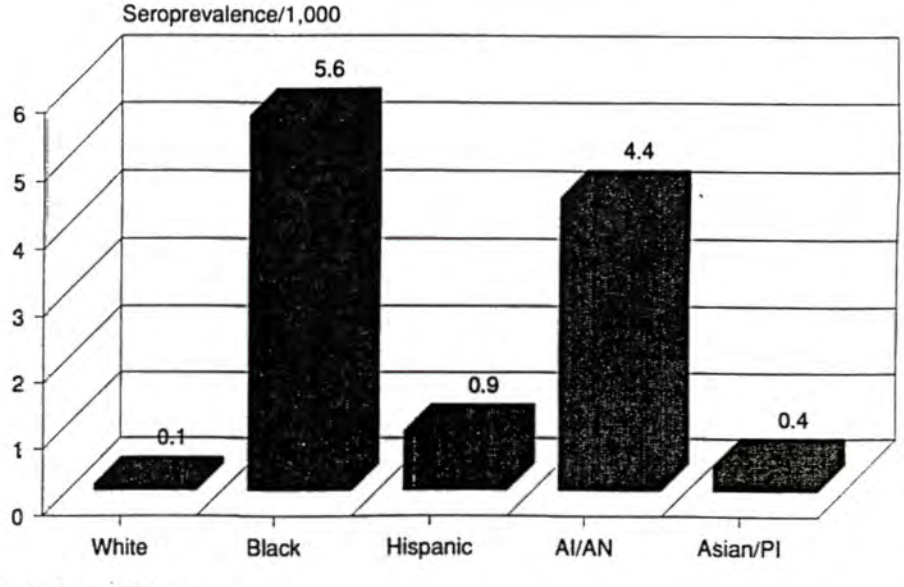
Source: CDC 1984-1988

Military Seroprevalence Rate/1,000 By Ethnicity 10/85-12/88



Source: Department of Defense

Military Recruit Seroprevalence Rate per 1,000 in California by Ethnicity



Source: Dept. of Defense

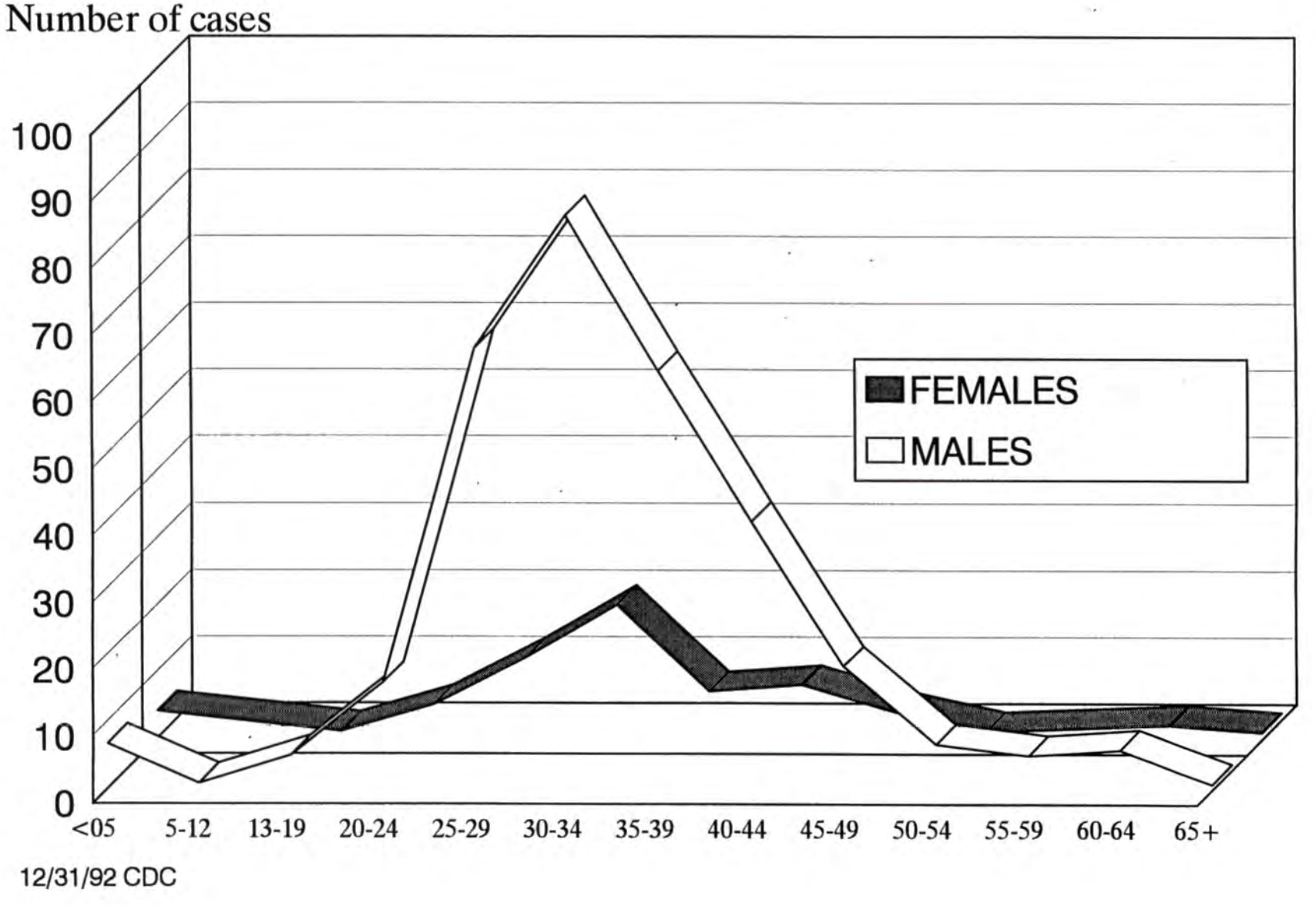
TEN LEADING CAUSES OF DEATH AMONG AMERICAN INDIANS/ALASKA NATIVES

1. Diseases of the Heart
2. Accidents
3. Malignant Neoplasms
4. Cerebrovascular Disease
5. Chronic Liver Disease and Cirrhosis
6. Homicide
7. Diabetes Mellitus
8. Suicide
9. Pneumonia
10. Chronic Pulmonary Disease

Source: Office of Technology Assessment

INDIAN AIDS CASES AGE AT DIAGNOSIS

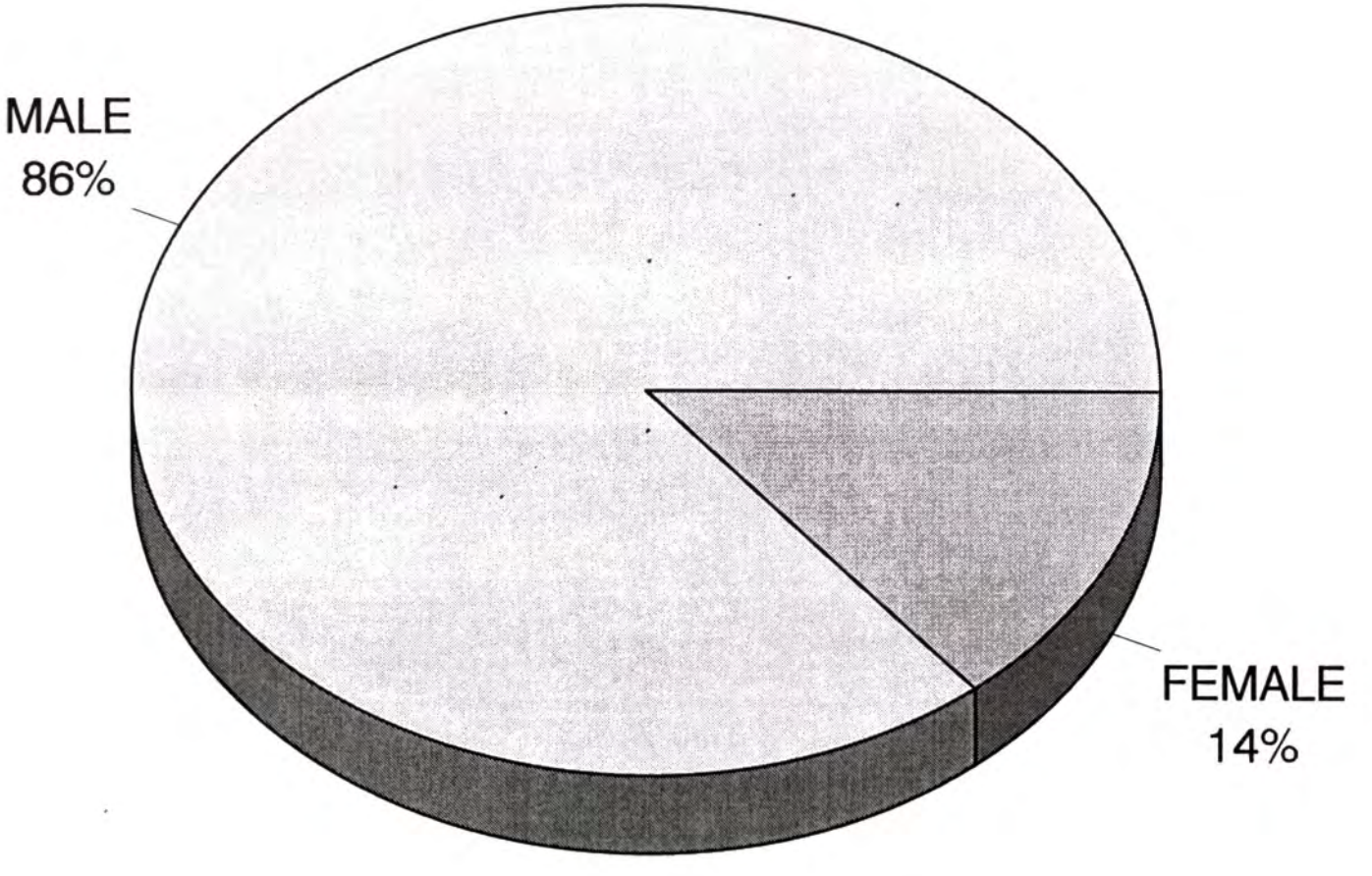
N=448



12/31/92 CDC

SEX OF ADULT NATIVE AIDS CASES

N=435

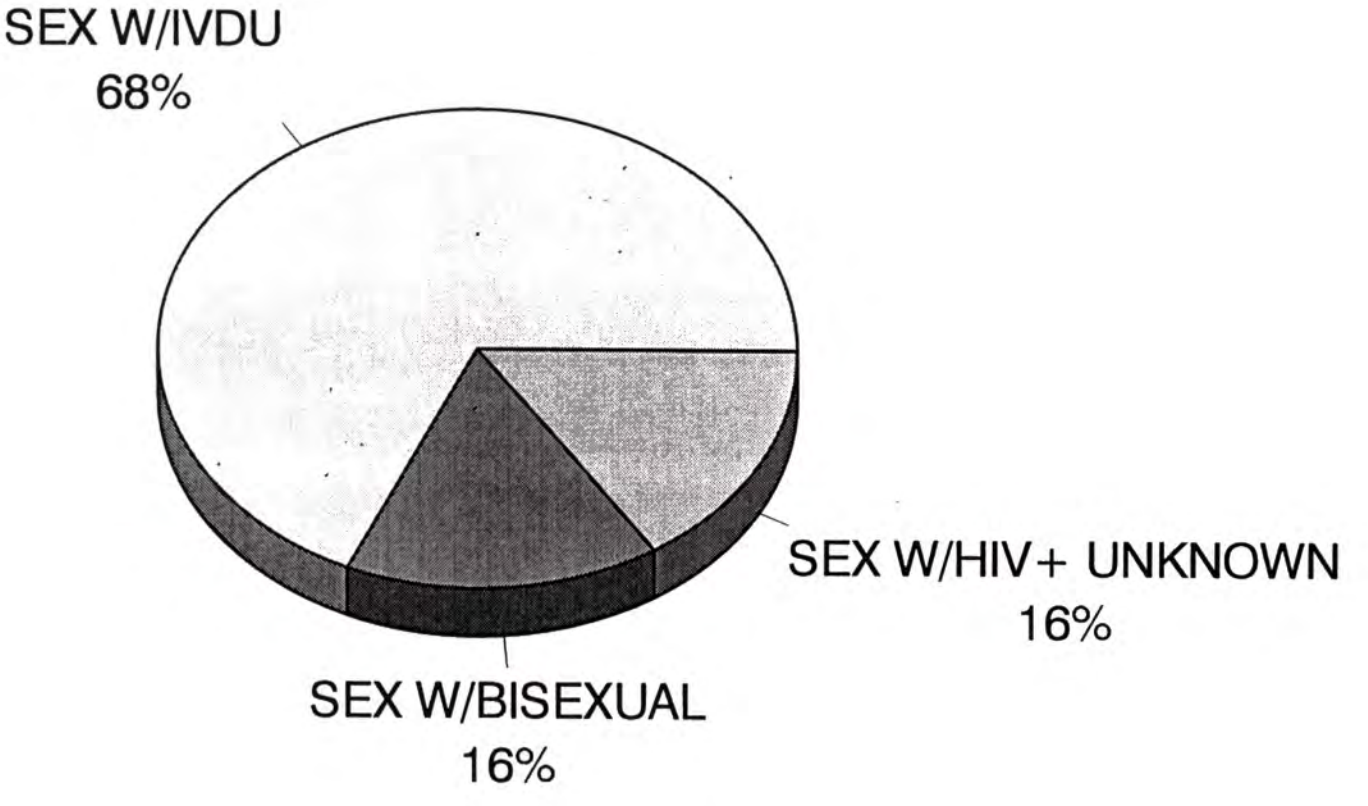


12/31/92 CDC

INDIAN HETEROSEXUAL CONTACT AIDS CASES

HOW WERE THEY INFECTED?

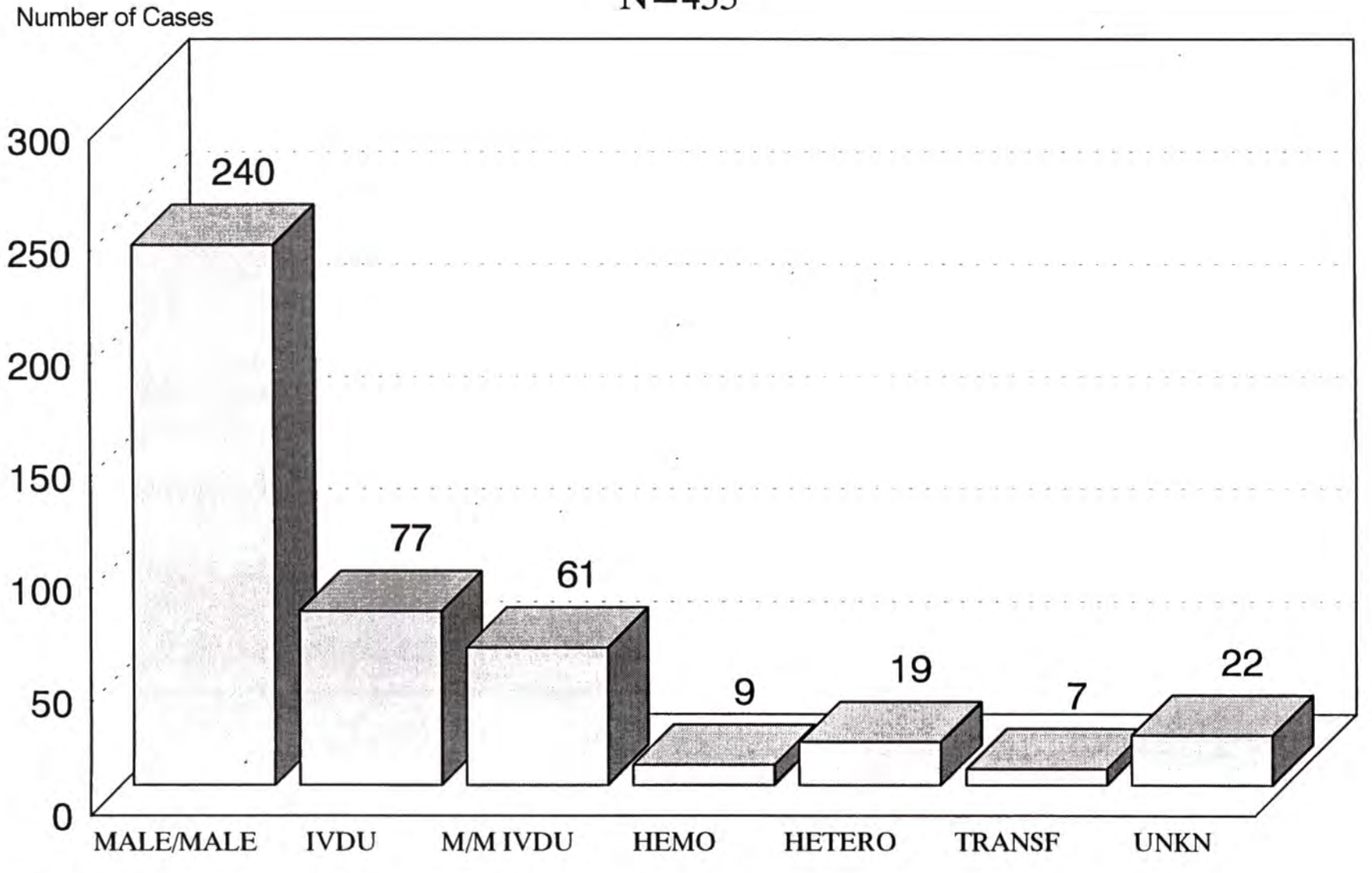
N=19



12/31/92 CDC

TRANSMISSION CATEGORIES FOR ADULT NATIVE AIDS CASES

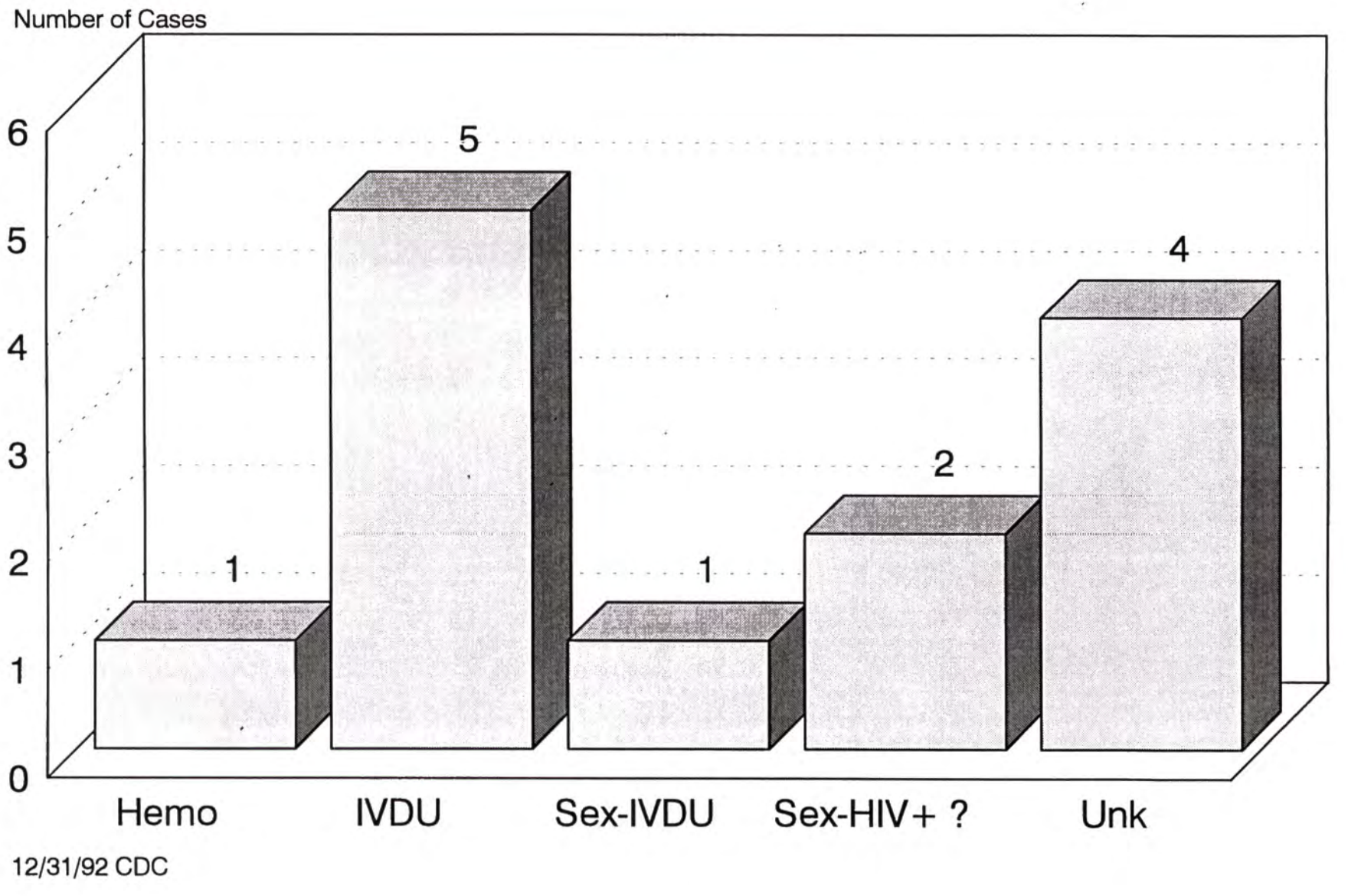
N=435



12/31/92 CDC

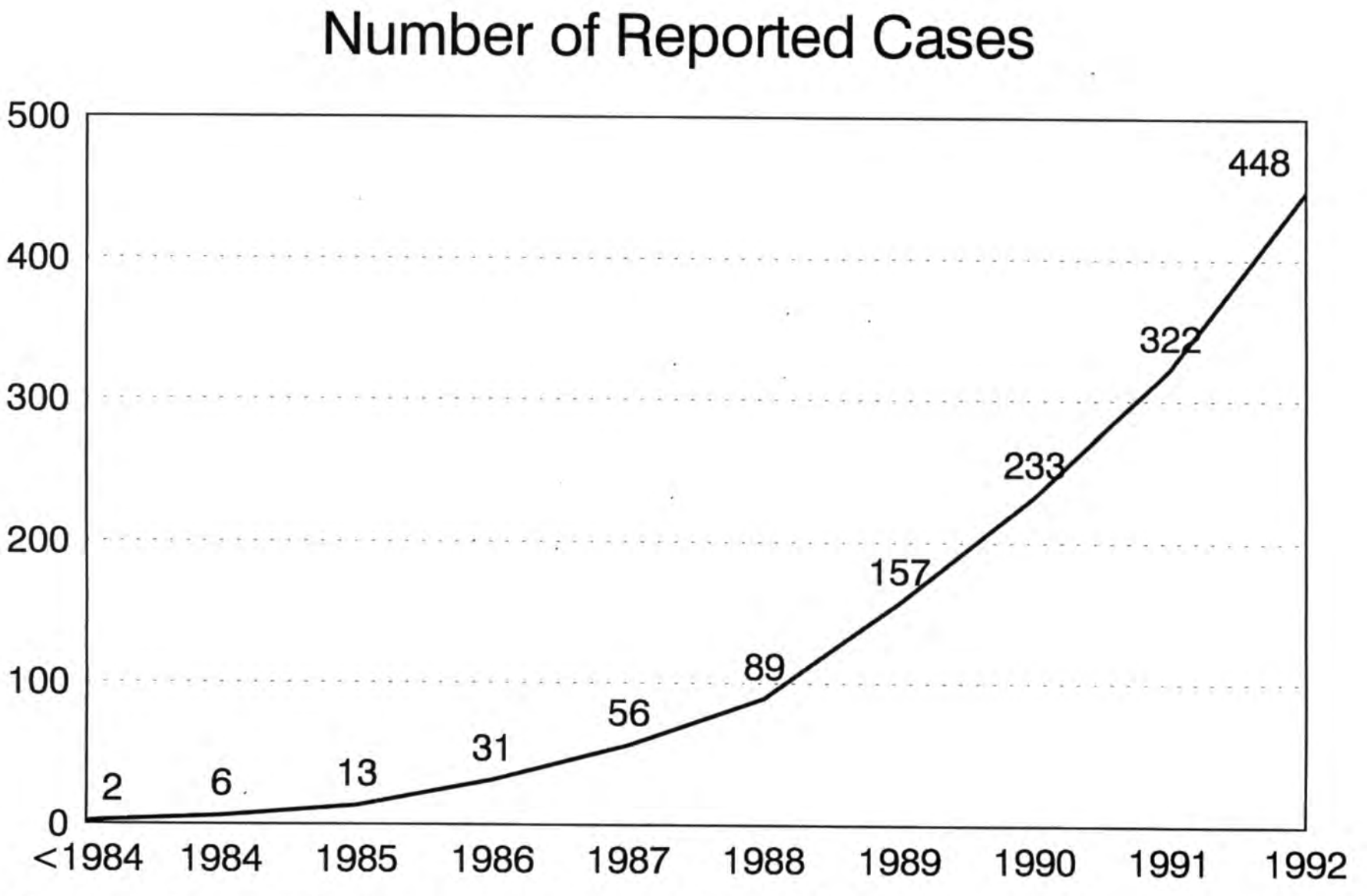
HOW WERE NATIVE CHILDREN INFECTED?

N=13



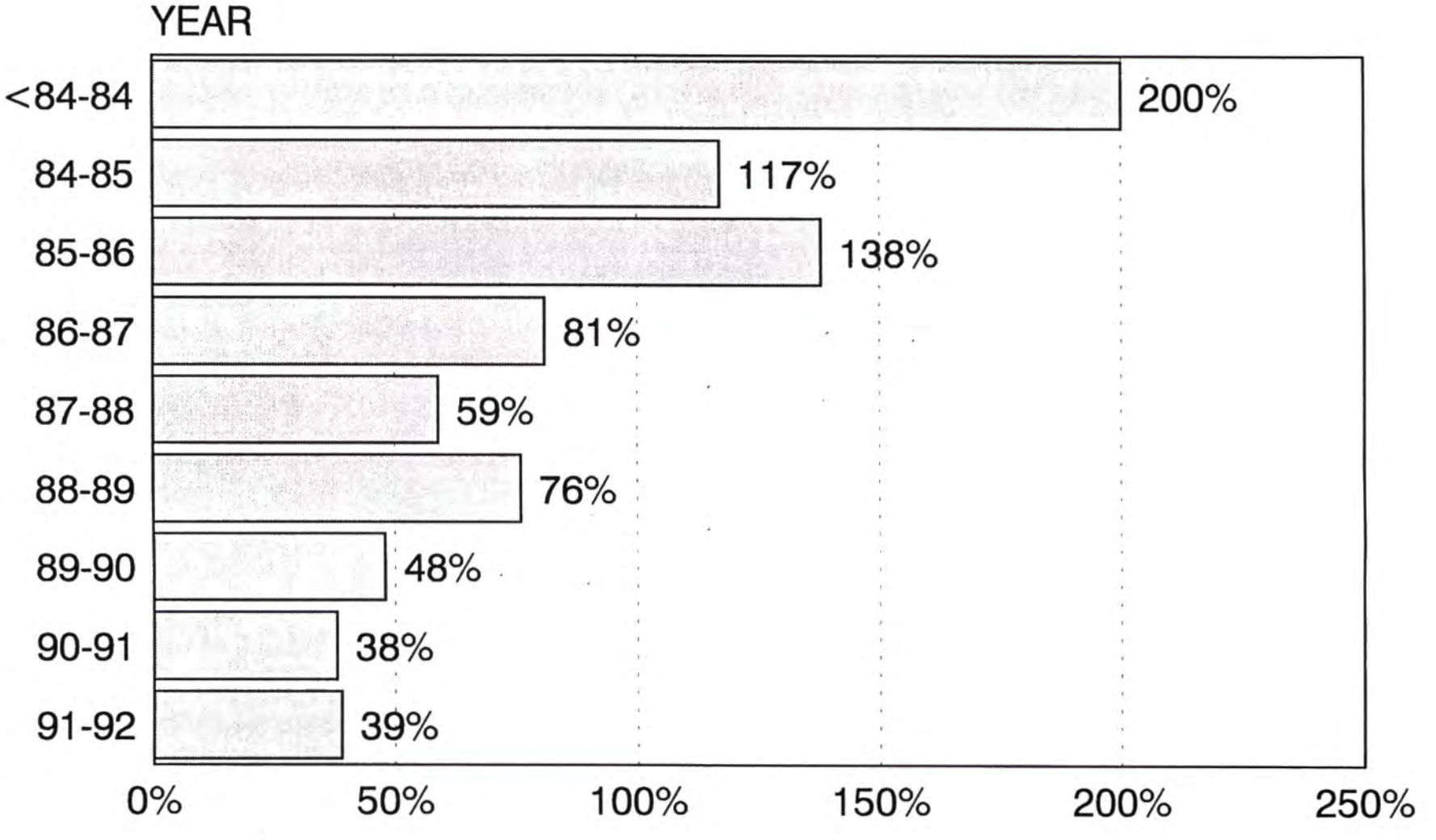
12/31/92 CDC

CUMULATIVE GROWTH IN NATIVE AIDS CASES BY YEAR



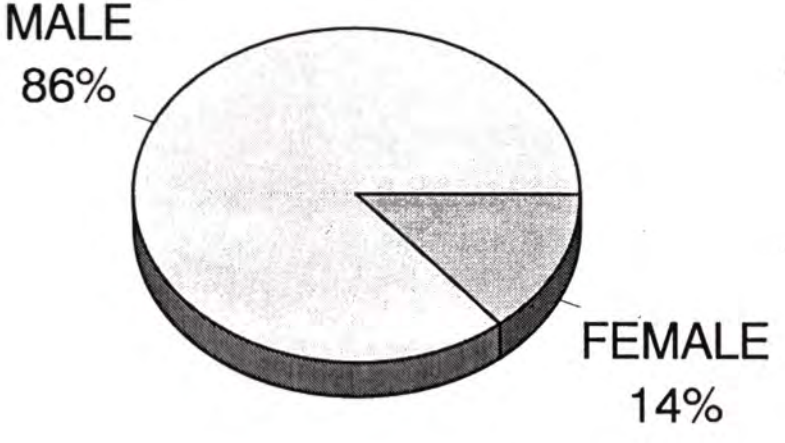
Source: Centers for Disease Control & Prevention

PERCENTAGE GROWTH BY YEAR OF NATIVE AIDS CASES

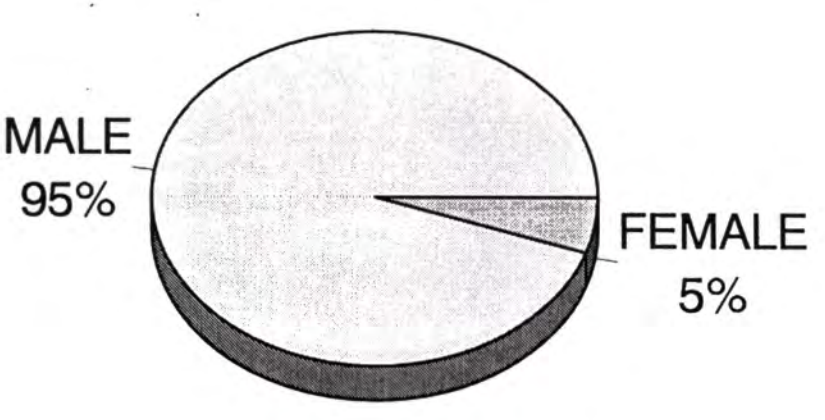


Source: Centers for Disease Control & Prevention

NATIVE VS. WHITE ADULT AIDS CASES BY SEX



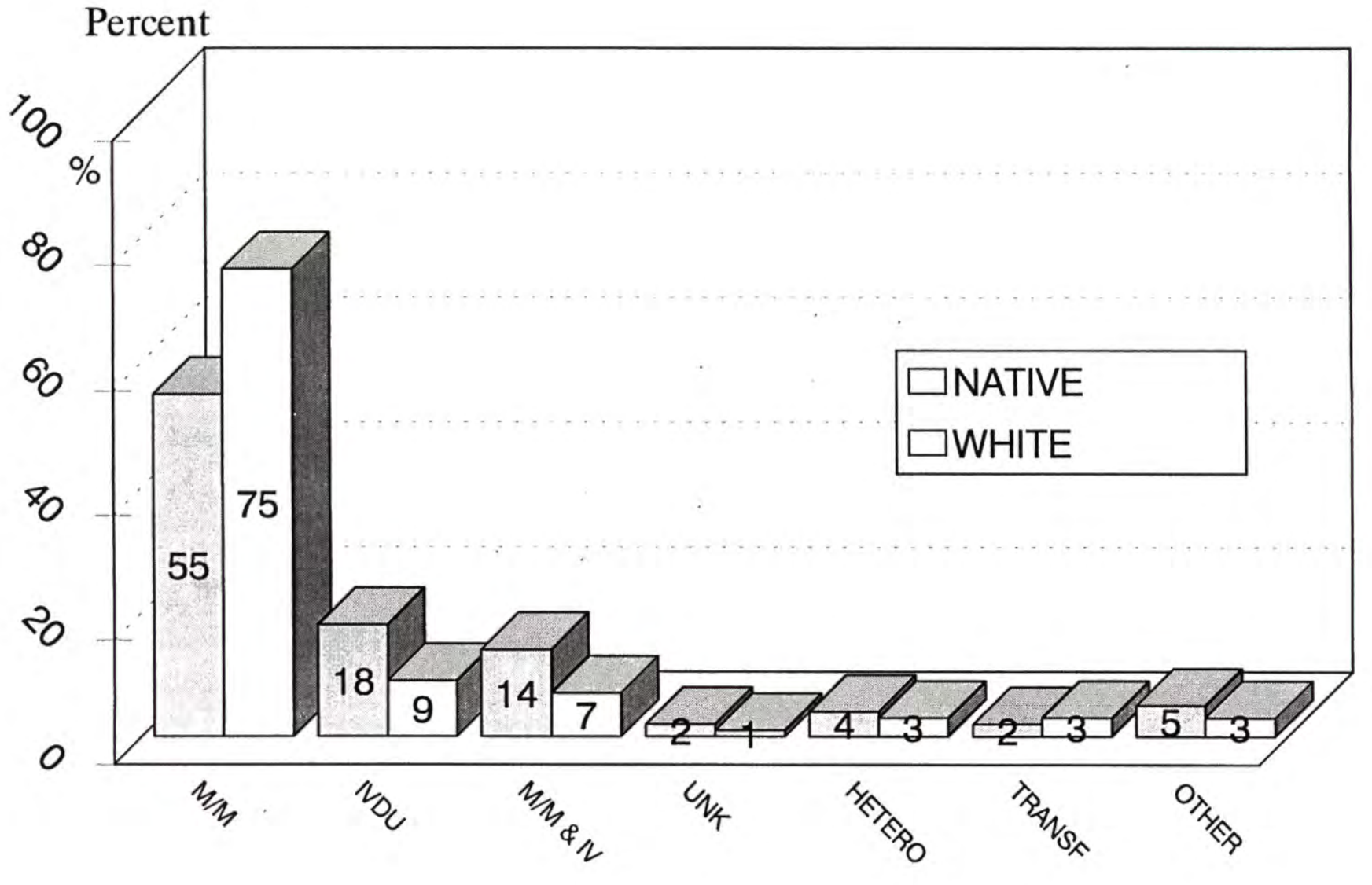
NATIVE



WHITE

12/31/92 CDC

NATIVE VS. WHITE/NON-HISPANIC ADULT TRANSMISSION



12/31/92 CDC

Table 4. Male adult/adolescent AIDS cases by exposure category and race/ethnicity, reported April 1992 through March 1993[1], and cumulative totals, through March 1993, United States

Exposure category	White, not Hispanic				Black, not Hispanic				Hispanic			
	Apr. 1992-Mar. 1993		Cumulative total		Apr. 1992-Mar. 1993		Cumulative total		Apr. 1992-Mar. 1993		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Men who have sex with men	23,211	(74)	110,868	(79)	7,084	(38)	29,108	(42)	4,341	(43)	18,438	(46)
Injecting drug use	2,855	(9)	10,319	(7)	6,319	(34)	24,231	(35)	3,638	(36)	15,200	(38)
Men who have sex with men and inject drugs	2,204	(7)	10,339	(7)	1,083	(6)	4,986	(7)	534	(5)	2,582	(6)
Hemophilia/coagulation disorder	560	(2)	2,018	(1)	79	(0)	207	(0)	45	(0)	190	(0)
Heterosexual contact:	411	(1)	1,326	(1)	1,529	(8)	5,125	(7)	447	(4)	1,056	(3)
Sex with injecting drug user	*155*		*686*		*583*		*1,772*		*172*		*511*	
Sex with person with hemophilia	*1*		*8*		*1*		*3*		*1*		*3*	
Born in Pattern-II[2] country	—		*7*		*406*		*2,247*		—		*11*	
Sex with person born in Pattern-II country	*7*		*49*		*18*		*67*		*3*		*11*	
Sex with transfusion recipient with HIV infection	*11*		*58*		*14*		*35*		*8*		*29*	
Sex with HIV-infected person, risk not specified	*237*		*518*		*507*		*1,001*		*263*		*491*	
Receipt of blood transfusion, blood components, or tissue	356	(1)	2,331	(2)	113	(1)	535	(1)	72	(1)	341	(1)
Risk not identified[3]	1,750	(6)	3,881	(3)	2,212	(12)	4,314	(6)	1,011	(10)	2,329	(6)
Total	**31,347**	**(100)**	**141,082**	**(100)**	**18,419**	**(100)**	**68,506**	**(100)**	**10,088**	**(100)**	**40,136**	**(100)**

Exposure category	Asian/Pacific Islander				American Indian/Alaska Native				Cumulative totals[4]			
	Apr. 1992-Mar. 1993		Cumulative total		Apr. 1992-Mar. 1993		Cumulative total		Apr. 1992-Mar. 1993		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Men who have sex with men	264	(71)	1,292	(79)	113	(67)	310	(65)	35,106	(58)	160,345	(64)
Injecting drug use	15	(4)	58	(4)	14	(8)	51	(11)	12,879	(21)	49,962	(20)
Men who have sex with men and inject drugs	11	(3)	41	(3)	27	(16)	77	(16)	3,864	(6)	18,041	(7)
Hemophilia/coagulation disorder	9	(2)	28	(2)	3	(2)	11	(2)	696	(1)	2,460	(1)
Heterosexual contact:	9	(2)	20	(1)	1	(1)	5	(1)	2,400	(4)	7,540	(3)
Sex with injecting drug user	*1*		*7*		—		*4*		*911*		*2,980*	
Sex with person with hemophilia	—		—		—		—		*4*		*15*	
Born in Pattern-II country	*1*		*3*		—		—		*409*		*2,274*	
Sex with person born in Pattern-II country	—		*1*		—		—		*28*		*128*	
Sex with transfusion recipient with HIV infection	*2*		*2*		—		—		*35*		*125*	
Sex with HIV-infected person, risk not specified	*5*		*7*		*1*		*1*		*1,013*		*2,018*	
Receipt of blood transfusion, blood components, or tissue	8	(2)	64	(4)	1	(1)	3	(1)	550	(1)	3,280	(1)
Risk not identified	58	(16)	126	(8)	10	(6)	19	(4)	5,071	(8)	10,735	(4)
Total	**374**	**(100)**	**1,629**	**(100)**	**169**	**(100)**	**476**	**(100)**	**60,566**	**(100)**	**252,363**	**(100)**

[1] Includes 3 months of data collected under the 1993 AIDS surveillance case definition for adults and adolescents.
[2] See technical notes.
[3] "Risk not identified" refers to persons whose mode of exposure to HIV is unknown. This includes persons under investigation; persons who died, were lost to follow-up, or declined interview; and persons whose mode of exposure to HIV remains unidentified after investigation. See Figure 6.
[4] Includes 534 men whose race/ethnicity is unknown.

Table 5. Female adult/adolescent AIDS cases by exposure category and race/ethnicity, reported April 1992 through March 1993[1], and cumulative totals, through March 1993, United States

Exposure category	White, not Hispanic				Black, not Hispanic				Hispanic			
	Apr. 1992-Mar. 1993		Cumulative total		Apr. 1992-Mar. 1993		Cumulative total		Apr. 1992-Mar. 1993		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Injecting drug use	1,047	(43)	3,481	(42)	2,459	(46)	9,097	(53)	818	(41)	3,136	(47)
Hemophilia/coagulation disorder	9	(0)	39	(0)	6	(0)	14	(0)	2	(0)	5	(0)
Heterosexual contact:	859	(35)	2,748	(33)	1,959	(37)	6,147	(36)	813	(41)	2,634	(40)
Sex with injecting drug user	*378*		*1,342*		*892*		*3,366*		*509*		*1,938*	
Sex with bisexual male	*121*		*495*		*94*		*337*		*39*		*121*	
Sex with person with hemophilia	*28*		*112*		*8*		*18*		*3*		*7*	
Born in Pattern-II[2] country	—		*2*		*218*		*965*		*3*		*8*	
Sex with person born in Pattern-II country	*1*		*12*		*18*		*91*		—		*3*	
Sex with transfusion recipient with HIV infection	*44*		*155*		*14*		*45*		*8*		*40*	
Sex with HIV-infected person, risk not specified	*287*		*630*		*715*		*1,325*		*251*		*517*	
Receipt of blood transfusion, blood components, or tissue	177	(7)	1,282	(16)	104	(2)	465	(3)	65	(3)	297	(4)
Risk not identified[3]	331	(14)	708	(9)	821	(15)	1,562	(9)	277	(14)	545	(8)
Total	**2,423**	**(100)**	**8,258**	**(100)**	**5,349**	**(100)**	**17,285**	**(100)**	**1,975**	**(100)**	**6,617**	**(100)**

Exposure category	Asian/Pacific Islander				American Indian/Alaska Native				Cumulative totals[4]			
	Apr. 1992-Mar. 1993		Cumulative total		Apr. 1992-Mar. 1993		Cumultaive total		Apr. 1992-Mar. 1993		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Injecting drug use	8	(13)	26	(15)	14	(50)	43	(55)	4,359	(44)	15,816	(49)
Hemophilia/coagulation disorder	1	(2)	1	(1)	—		—		18	(0)	59	(0)
Heterosexual contact:	31	(49)	68	(39)	8	(29)	20	(26)	3,672	(37)	11,638	(36)
Sex with injecting drug user	*8*		*21*		*6*		*15*		*1,793*		*6,696*	
Sex with bisexual male	*9*		*21*		*1*		*3*		*265*		*980*	
Sex with person with hemophilia	—		*2*		—		—		*39*		*139*	
Born in Pattern-II country	*1*		*1*		—		—		*222*		*977*	
Sex with person born in Pattern-II country	—		—		—		—		*19*		*106*	
Sex with transfusion recipient with HIV infection	*2*		*4*		—		—		*68*		*245*	
Sex with HIV-infected person, risk not specified	*11*		*19*		*1*		*2*		*1,266*		*2,495*	
Receipt of blood transfusion, blood components, or tissue	10	(16)	49	(28)	3	(11)	8	(10)	359	(4)	2,104	(6)
Risk not identified	13	(21)	31	(18)	3	(11)	7	(9)	1,450	(15)	2,860	(9)
Total	**63**	**(100)**	**175**	**(100)**	**28**	**(100)**	**78**	**(100)**	**9,858**	**(100)**	**32,477**	**(100)**

[1] Includes 3 months of data collected under the 1993 AIDS surveillance case definition for adults and adolescents.
[2] See technical notes.
[3] "Risk not identified" refers to persons whose mode of exposure to HIV is unknown. This includes persons under investigation; persons who died, were lost to follow-up, or declined interview; and persons whose mode of exposure to HIV remains unidentified after investigation. See Figure 6.
[4] Includes 64 women whose race/ethnicity is unknown.

Table 6. Pediatric AIDS cases by exposure category and race/ethnicity, reported April 1992 through March 1993, and cumulative totals, through March 1993, United States

Exposure category	White, not Hispanic				Black, not Hispanic				Hispanic			
	Apr. 1992-Mar. 1993		Cumulative total		Apr. 1992-Mar. 1993		Cumulative total		Apr. 1992-Mar. 1993		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Hemophilia/coagulation disorder	9	(7)	131	(14)	3	(1)	26	(1)	5	(3)	33	(3)
Mother with/at risk for HIV infection:	100	(83)	598	(66)	442	(95)	2,300	(94)	155	(90)	957	(88)
Injecting drug use	*32*		*269*		*148*		*1,044*		*55*		*443*	
Sex with injecting drug user	*13*		*111*		*58*		*348*		*40*		*295*	
Sex with bisexual male	*10*		*37*		*1*		*28*		—		*17*	
Sex with person with hemophilia	*2*		*12*		*1*		*5*		*1*		*3*	
Born in Pattern-II[1] country	—		*3*		*36*		*288*		—		*2*	
Sex with person born in Pattern-II country	—		—		*6*		*18*		—		*1*	
Sex with transfusion recipient with HIV infection	*1*		*6*		—		*4*		*2*		*8*	
Sex with HIV-infected person, risk not specified	*9*		*41*		*50*		*127*		*18*		*62*	
Receipt of blood transfusion, blood components, or tissue	*5*		*26*		*11*		*40*		*10*		*24*	
Has HIV infection, risk not specified	*28*		*93*		*131*		*398*		*29*		*102*	
Receipt of blood transfusion, blood components, or tissue	6	(5)	162	(18)	5	(1)	70	(3)	8	(5)	75	(7)
Risk not identified[2]	6	(5)	16	(2)	17	(4)	51	(2)	4	(2)	17	(2)
Total	**121**	**(100)**	**907**	**(100)**	**467**	**(100)**	**2,447**	**(100)**	**172**	**(100)**	**1,082**	**(100)**

Exposure category	Asian/Pacific Islander				American Indian/Alaska Native				Cumulative totals[3]			
	Apr. 1992-Mar. 1993		Cumulative total		Apr. 1992-Mar. 1993		Cumulative total		Apr. 1992-Mar. 1993		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Hemophilia/coagulation disorder	—		3	(16)	1	(20)	1	(7)	18	(2)	194	(4)
Mother with/at risk for HIV infection:	1	(100)	9	(47)	4	(80)	14	(93)	707	(92)	3,887	(87)
Injecting drug use	*1*		*3*		*1*		*5*		*241*		*1,768*	
Sex with injecting drug user	—		*2*		*2*		*3*		*113*		*761*	
Sex with bisexual male	—		*1*		—		—		*11*		*83*	
Sex with person with hemophilia	—		—		—		—		*4*		*20*	
Born in Pattern-II country	—		—		—		—		*36*		*293*	
Sex with person born in Pattern-II country	—		—		—		—		*6*		*20*	
Sex with transfusion recipient with HIV infection	—		—		—		—		*3*		*18*	
Sex with HIV-infected person, risk not specified	—		*1*		—		*2*		*77*		*234*	
Receipt of blood transfusion, blood components, or tissue	—		—		—		—		*26*		*90*	
Has HIV infection, risk not specified	—		*2*		*1*		*4*		*190*		*600*	
Receipt of blood transfusion, blood components, or tissue	—		7	(37)	—		—		20	(3)	315	(7)
Risk not identified	—		—		—		—		27	(3)	84	(2)
Total	**1**	**(100)**	**19**	**(100)**	**5**	**(100)**	**15**	**(100)**	**772**	**(100)**	**4,480**	**(100)**

[1] See technical notes.

[2] "Risk not identified" refers to persons whose mode of exposure to HIV is unknown. This includes persons under investigation; persons who died, were lost to follow-up, or declined interview; and persons whose mode of exposure to HIV remains unidentified after investigation. See Figure 6.

[3] Includes 10 children whose race/ethnicity is unknown.

Table 8 AIDS cases by sex, age at diagnosis, and race/ethnicity, reported through March 1993[1], United States

Males	White, not Hispanic		Black, not Hispanic		Hispanic		Asian/Pacific Islander		American Indian/ Alaska Native		Total[2]	
Age at diagnosis (years)	**No.**	**(%)**	**No.**	**(%)**	**No.**	**(%)**	**No.**	**(%)**	**No.**	**(%)**	**No.**	**(%)**
Under 5	304	(0)	1,063	(2)	443	(1)	7	(0)	8	(2)	1,828	(1)
5-12	228	(0)	168	(0)	132	(0)	6	(0)	1	(0)	535	(0)
13-19	393	(0)	261	(0)	157	(0)	8	(0)	9	(2)	828	(0)
20-24	4,222	(3)	2,817	(4)	1,693	(4)	57	(3)	21	(4)	8,824	(3)
25-29	20,725	(15)	10,323	(15)	6,618	(16)	222	(14)	92	(19)	38,057	(15)
30-34	32,997	(23)	16,222	(23)	10,009	(25)	334	(20)	132	(27)	59,804	(23)
35-39	31,424	(22)	16,219	(23)	9,022	(22)	359	(22)	98	(20)	57,256	(22)
40-44	22,304	(16)	10,629	(15)	5,917	(15)	279	(17)	61	(13)	39,282	(15)
45-49	13,155	(9)	5,540	(8)	3,136	(8)	180	(11)	31	(6)	22,090	(9)
50–54	7,130	(5)	3,083	(4)	1,723	(4)	88	(5)	13	(3)	12,065	(5)
55–59	4,147	(3)	1,754	(3)	1,008	(2)	51	(3)	10	(2)	6,992	(3)
60–64	2,487	(2)	949	(1)	499	(1)	16	(1)	7	(1)	3,963	(2)
65 or older	2,098	(1)	709	(1)	354	(1)	35	(2)	2	(0)	3,202	(1)
Male subtotal	141,614	(100)	69,737	(100)	40,711	(100)	1,642	(100)	485	(100)	254,726	(100)
Females												
Age at diagnosis (years)												
Under 5	302	(3)	1,050	(6)	413	(6)	—		6	(7)	1,777	(5)
5-12	73	(1)	166	(1)	94	(1)	6	(3)	—		340	(1)
13-19	84	(1)	200	(1)	52	(1)	1	(1)	1	(1)	339	(1)
20-24	542	(6)	1,085	(6)	477	(7)	7	(4)	7	(8)	2,125	(6)
25-29	1,532	(18)	3,145	(17)	1,396	(20)	18	(10)	15	(18)	6,114	(18)
30-34	1,925	(22)	4,549	(25)	1,717	(24)	34	(19)	24	(29)	8,264	(24)
35-39	1,467	(17)	3,993	(22)	1,358	(19)	28	(15)	11	(13)	6,873	(20)
40-44	853	(10)	2,148	(12)	783	(11)	34	(19)	10	(12)	3,835	(11)
45-49	448	(5)	898	(5)	353	(5)	16	(9)	5	(6)	1,726	(5)
50-54	295	(3)	554	(3)	214	(3)	9	(5)	1	(1)	1,074	(3)
55-59	295	(3)	312	(2)	124	(2)	7	(4)	1	(1)	741	(2)
60-64	228	(3)	199	(1)	69	(1)	10	(6)	2	(2)	508	(1)
65 or older	589	(7)	202	(1)	74	(1)	11	(6)	1	(1)	878	(3)
Female subtotal	8,633	(100)	18,501	(100)	7,124	(100)	181	(100)	84	(100)	34,594	(100)
Total	**150,247**		**88,238**		**47,835**		**1,823**		**569**		**289,320**	

[1]Includes 3 months of data collected under the 1993 AIDS surveillance case definition for adults and adolescents.
[2]Includes 537 males and 71 females whose race/ethnicity is unknown.

Table 4. Male adult/adolescent AIDS cases by exposure category and race/ethnicity, reported April 1992 through March 1993[1], and cumulative totals, through March 1993, United States

Exposure category	White, not Hispanic				Black, not Hispanic				Hispanic			
	Apr. 1992-Mar. 1993		Cumulative total		Apr. 1992-Mar. 1993		Cumulative total		Apr. 1992-Mar. 1993		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Men who have sex with men	23,211	(74)	110,868	(79)	7,084	(38)	29,108	(42)	4,341	(43)	18,438	(46)
Injecting drug use	2,855	(9)	10,319	(7)	6,319	(34)	24,231	(35)	3,638	(36)	15,200	(38)
Men who have sex with men and inject drugs	2,204	(7)	10,339	(7)	1,083	(6)	4,986	(7)	534	(5)	2,582	(6)
Hemophilia/coagulation disorder	560	(2)	2,018	(1)	79	(0)	207	(0)	45	(0)	190	(0)
Heterosexual contact:	411	(1)	1,326	(1)	1,529	(8)	5,125	(7)	447	(4)	1,056	(3)
Sex with injecting drug user	*155*		*686*		*583*		*1,772*		*172*		*511*	
Sex with person with hemophilia	*1*		*8*		*1*		*3*		*1*		*3*	
Born in Pattern-II[2] country	*—*		*7*		*406*		*2,247*		*—*		*11*	
Sex with person born in Pattern-II country	*7*		*49*		*18*		*67*		*3*		*11*	
Sex with transfusion recipient with HIV infection	*11*		*58*		*14*		*35*		*8*		*29*	
Sex with HIV-infected person, risk not specified	*237*		*518*		*507*		*1,001*		*263*		*491*	
Receipt of blood transfusion, blood components, or tissue	356	(1)	2,331	(2)	113	(1)	535	(1)	72	(1)	341	(1)
Risk not identified[3]	1,750	(6)	3,881	(3)	2,212	(12)	4,314	(6)	1,011	(10)	2,329	(6)
Total	**31,347**	**(100)**	**141,082**	**(100)**	**18,419**	**(100)**	**68,506**	**(100)**	**10,088**	**(100)**	**40,136**	**(100)**

Exposure category	Asian/Pacific Islander				American Indian/Alaska Native				Cumulative totals[4]			
	Apr. 1992-Mar. 1993		Cumulative total		Apr. 1992-Mar. 1993		Cumulative total		Apr. 1992-Mar. 1993		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Men who have sex with men	264	(71)	1,292	(79)	113	(67)	310	(65)	35,106	(58)	160,345	(64)
Injecting drug use	15	(4)	58	(4)	14	(8)	51	(11)	12,879	(21)	49,962	(20)
Men who have sex with men and inject drugs	11	(3)	41	(3)	27	(16)	77	(16)	3,864	(6)	18,041	(7)
Hemophilia/coagulation disorder	9	(2)	28	(2)	3	(2)	11	(2)	696	(1)	2,460	(1)
Heterosexual contact:	9	(2)	20	(1)	1	(1)	5	(1)	2,400	(4)	7,540	(3)
Sex with injecting drug user	*1*		*7*		*—*		*4*		*911*		*2,980*	
Sex with person with hemophilia	*—*		*—*		*—*		*—*		*4*		*15*	
Born in Pattern-II country	*1*		*3*		*—*		*—*		*409*		*2,274*	
Sex with person born in Pattern-II country	*—*		*1*		*—*		*—*		*28*		*128*	
Sex with transfusion recipient with HIV infection	*2*		*2*		*—*		*—*		*35*		*125*	
Sex with HIV-infected person, risk not specified	*5*		*7*		*1*		*1*		*1,013*		*2,018*	
Receipt of blood transfusion, blood components, or tissue	8	(2)	64	(4)	1	(1)	3	(1)	550	(1)	3,280	(1)
Risk not identified	58	(16)	126	(8)	10	(6)	19	(4)	5,071	(8)	10,735	(4)
Total	**374**	**(100)**	**1,629**	**(100)**	**169**	**(100)**	**476**	**(100)**	**60,566**	**(100)**	**252,363**	**(100)**

[1] Includes 3 months of data collected under the 1993 AIDS surveillance case definition for adults and adolescents.
[2] See technical notes.
[3] "Risk not identified" refers to persons whose mode of exposure to HIV is unknown. This includes persons under investigation; persons who died, were lost to follow-up, or declined interview; and persons whose mode of exposure to HIV remains unidentified after investigation. See Figure 6.
[4] Includes 534 men whose race/ethnicity is unknown.

Table 5. Female adult/adolescent AIDS cases by exposure category and race/ethnicity, reported April 1992 through March 1993[1], and cumulative totals, through March 1993, United States

Exposure category	White, not Hispanic				Black, not Hispanic				Hispanic			
	Apr. 1992-Mar. 1993		Cumulative total		Apr. 1992-Mar. 1993		Cumulative total		Apr. 1992-Mar. 1993		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Injecting drug use	1,047	(43)	3,481	(42)	2,459	(46)	9,097	(53)	818	(41)	3,136	(47)
Hemophilia/coagulation disorder	9	(0)	39	(0)	6	(0)	14	(0)	2	(0)	5	(0)
Heterosexual contact:	859	(35)	2,748	(33)	1,959	(37)	6,147	(36)	813	(41)	2,634	(40)
Sex with injecting drug user	*378*		*1,342*		*892*		*3,366*		*509*		*1,938*	
Sex with bisexual male	*121*		*495*		*94*		*337*		*39*		*121*	
Sex with person with hemophilia	*28*		*112*		*8*		*18*		*3*		*7*	
Born in Pattern-II[2] country	—		*2*		*218*		*965*		*3*		*8*	
Sex with person born in Pattern-II country	*1*		*12*		*18*		*91*		—		*3*	
Sex with transfusion recipient with HIV infection	*44*		*155*		*14*		*45*		*8*		*40*	
Sex with HIV-infected person, risk not specified	*287*		*630*		*715*		*1,325*		*251*		*517*	
Receipt of blood transfusion, blood components, or tissue	177	(7)	1,282	(16)	104	(2)	465	(3)	65	(3)	297	(4)
Risk not identified[3]	331	(14)	708	(9)	821	(15)	1,562	(9)	277	(14)	545	(8)
Total	**2,423**	**(100)**	**8,258**	**(100)**	**5,349**	**(100)**	**17,285**	**(100)**	**1,975**	**(100)**	**6,617**	**(100)**

Exposure category	Asian/Pacific Islander				American Indian/Alaska Native				Cumulative totals[4]			
	Apr. 1992-Mar. 1993		Cumulative total		Apr. 1992-Mar. 1993		Cumultaive total		Apr. 1992-Mar. 1993		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Injecting drug use	8	(13)	26	(15)	14	(50)	43	(55)	4,359	(44)	15,816	(49)
Hemophilia/coagulation disorder	1	(2)	1	(1)	—		—		18	(0)	59	(0)
Heterosexual contact:	31	(49)	68	(39)	8	(29)	20	(26)	3,672	(37)	11,638	(36)
Sex with injecting drug user	*8*		*21*		*6*		*15*		*1,793*		*6,696*	
Sex with bisexual male	*9*		*21*		*1*		*3*		*265*		*980*	
Sex with person with hemophilia	—		*2*		—		—		*39*		*139*	
Born in Pattern-II country	*1*		*1*		—		—		*222*		*977*	
Sex with person born in Pattern-II country	—		—		—		—		*19*		*106*	
Sex with transfusion recipient with HIV infection	*2*		*4*		—		—		*68*		*245*	
Sex with HIV-infected person, risk not specified	*11*		*19*		*1*		*2*		*1,266*		*2,495*	
Receipt of blood transfusion, blood components, or tissue	10	(16)	49	(28)	3	(11)	8	(10)	359	(4)	2,104	(6)
Risk not identified	13	(21)	31	(18)	3	(11)	7	(9)	1,450	(15)	2,860	(9)
Total	**63**	**(100)**	**175**	**(100)**	**28**	**(100)**	**78**	**(100)**	**9,858**	**(100)**	**32,477**	**(100)**

[1] Includes 3 months of data collected under the 1993 AIDS surveillance case definition for adults and adolescents.
[2] See technical notes.
[3] "Risk not identified" refers to persons whose mode of exposure to HIV is unknown. This includes persons under investigation; persons who died, were lost to follow-up, or declined interview; and persons whose mode of exposure to HIV remains unidentified after investigation. See Figure 6.
[4] Includes 64 women whose race/ethnicity is unknown.

Table 6. Pediatric AIDS cases by exposure category and race/ethnicity, reported April 1992 through March 1993, and cumulative totals, through March 1993, United States

Exposure category	White, not Hispanic				Black, not Hispanic				Hispanic			
	Apr. 1992-Mar. 1993		Cumulative total		Apr. 1992-Mar. 1993		Cumulative total		Apr. 1992-Mar. 1993		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Hemophilia/coagulation disorder	9	(7)	131	(14)	3	(1)	26	(1)	5	(3)	33	(3)
Mother with/at risk for HIV infection:	100	(83)	598	(66)	442	(95)	2,300	(94)	155	(90)	957	(88)
Injecting drug use	*32*		*269*		*148*		*1,044*		*55*		*443*	
Sex with injecting drug user	*13*		*111*		*58*		*348*		*40*		*295*	
Sex with bisexual male	*10*		*37*		*1*		*28*		—		*17*	
Sex with person with hemophilia	*2*		*12*		*1*		*5*		*1*		*3*	
Born in Pattern-II[1] country	—		*3*		*36*		*288*		—		*2*	
Sex with person born in Pattern-II country	—		—		*6*		*18*		—		*1*	
Sex with transfusion recipient with HIV infection	*1*		*6*		—		*4*		*2*		*8*	
Sex with HIV-infected person, risk not specified	*9*		*41*		*50*		*127*		*18*		*62*	
Receipt of blood transfusion, blood components, or tissue	*5*		*26*		*11*		*40*		*10*		*24*	
Has HIV infection, risk not specified	*28*		*93*		*131*		*398*		*29*		*102*	
Receipt of blood transfusion, blood components, or tissue	6	(5)	162	(18)	5	(1)	70	(3)	8	(5)	75	(7)
Risk not identified[2]	6	(5)	16	(2)	17	(4)	51	(2)	4	(2)	17	(2)
Total	**121**	**(100)**	**907**	**(100)**	**467**	**(100)**	**2,447**	**(100)**	**172**	**(100)**	**1,082**	**(100)**

Exposure category	Asian/Pacific Islander				American Indian/Alaska Native				Cumulative totals[3]			
	Apr. 1992-Mar. 1993		Cumulative total		Apr. 1992-Mar. 1993		Cumulative total		Apr. 1992-Mar. 1993		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Hemophilia/coagulation disorder	—		3	(16)	1	(20)	1	(7)	18	(2)	194	(4)
Mother with/at risk for HIV infection:	1	(100)	9	(47)	4	(80)	14	(93)	707	(92)	3,887	(87)
Injecting drug use	*1*		*3*		*1*		*5*		*241*		*1,768*	
Sex with injecting drug user	—		*2*		*2*		*3*		*113*		*761*	
Sex with bisexual male	—		*1*		—		—		*11*		*83*	
Sex with person with hemophilia	—		—		—		—		*4*		*20*	
Born in Pattern-II country	—		—		—		—		*36*		*293*	
Sex with person born in Pattern-II country	—		—		—		—		*6*		*20*	
Sex with transfusion recipient with HIV infection	—		—		—		—		*3*		*18*	
Sex with HIV-infected person, risk not specified	—		*1*		—		*2*		*77*		*234*	
Receipt of blood transfusion, blood components, or tissue	—		—		—		—		*26*		*90*	
Has HIV infection, risk not specified	—		*2*		*1*		*4*		*190*		*600*	
Receipt of blood transfusion, blood components, or tissue	—		7	(37)	—		—		20	(3)	315	(7)
Risk not identified	—		—		—		—		27	(3)	84	(2)
Total	**1**	**(100)**	**19**	**(100)**	**5**	**(100)**	**15**	**(100)**	**772**	**(100)**	**4,480**	**(100)**

[1] See technical notes.

[2] "Risk not identified" refers to persons whose mode of exposure to HIV is unknown. This includes persons under investigation; persons who died, were lost to follow-up, or declined interview; and persons whose mode of exposure to HIV remains unidentified after investigation. See Figure 6.

[3] Includes 10 children whose race/ethnicity is unknown.

Table 8 AIDS cases by sex, age at diagnosis, and race/ethnicity, reported through March 1993[1], United States

Males	White, not Hispanic		Black, not Hispanic		Hispanic		Asian/Pacific Islander		American Indian/ Alaska Native		Total[2]	
Age at diagnosis (years)	**No.**	**(%)**	**No.**	**(%)**	**No.**	**(%)**	**No.**	**(%)**	**No.**	**(%)**	**No.**	**(%)**
Under 5	304	(0)	1,063	(2)	443	(1)	7	(0)	8	(2)	1,828	(1)
5-12	228	(0)	168	(0)	132	(0)	6	(0)	1	(0)	535	(0)
13-19	393	(0)	261	(0)	157	(0)	8	(0)	9	(2)	828	(0)
20-24	4,222	(3)	2,817	(4)	1,693	(4)	57	(3)	21	(4)	8,824	(3)
25-29	20,725	(15)	10,323	(15)	6,618	(16)	222	(14)	92	(19)	38,057	(15)
30-34	32,997	(23)	16,222	(23)	10,009	(25)	334	(20)	132	(27)	59,804	(23)
35-39	31,424	(22)	16,219	(23)	9,022	(22)	359	(22)	98	(20)	57,256	(22)
40-44	22,304	(16)	10,629	(15)	5,917	(15)	279	(17)	61	(13)	39,282	(15)
45-49	13,155	(9)	5,540	(8)	3,136	(8)	180	(11)	31	(6)	22,090	(9)
50–54	7,130	(5)	3,083	(4)	1,723	(4)	88	(5)	13	(3)	12,065	(5)
55–59	4,147	(3)	1,754	(3)	1,008	(2)	51	(3)	10	(2)	6,992	(3)
60–64	2,487	(2)	949	(1)	499	(1)	16	(1)	7	(1)	3,963	(2)
65 or older	2,098	(1)	709	(1)	354	(1)	35	(2)	2	(0)	3,202	(1)
Male subtotal	141,614	(100)	69,737	(100)	40,711	(100)	1,642	(100)	485	(100)	254,726	(100)
Females												
Age at diagnosis (years)												
Under 5	302	(3)	1,050	(6)	413	(6)	—		6	(7)	1,777	(5)
5-12	73	(1)	166	(1)	94	(1)	6	(3)	—		340	(1)
13-19	84	(1)	200	(1)	52	(1)	1	(1)	1	(1)	339	(1)
20-24	542	(6)	1,085	(6)	477	(7)	7	(4)	7	(8)	2,125	(6)
25-29	1,532	(18)	3,145	(17)	1,396	(20)	18	(10)	15	(18)	6,114	(18)
30-34	1,925	(22)	4,549	(25)	1,717	(24)	34	(19)	24	(29)	8,264	(24)
35-39	1,467	(17)	3,993	(22)	1,358	(19)	28	(15)	11	(13)	6,873	(20)
40-44	853	(10)	2,148	(12)	783	(11)	34	(19)	10	(12)	3,835	(11)
45-49	448	(5)	898	(5)	353	(5)	16	(9)	5	(6)	1,726	(5)
50-54	295	(3)	554	(3)	214	(3)	9	(5)	1	(1)	1,074	(3)
55-59	295	(3)	312	(2)	124	(2)	7	(4)	1	(1)	741	(2)
60-64	228	(3)	199	(1)	69	(1)	10	(6)	2	(2)	508	(1)
65 or older	589	(7)	202	(1)	74	(1)	11	(6)	1	(1)	878	(3)
Female subtotal	8,633	(100)	18,501	(100)	7,124	(100)	181	(100)	84	(100)	34,594	(100)
Total	**150,247**		**88,238**		**47,835**		**1,823**		**569**		**289,320**	

[1]Includes 3 months of data collected under the 1993 AIDS surveillance case definition for adults and adolescents.
[2]Includes 537 males and 71 females whose race/ethnicity is unknown.

NATIVE AMERICANS, STEREOTYPES, AND HIV/AIDS

Our Continuing Struggle for Survival

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A discussion of the AIDS epidemic among Native American people requires a brief introduction to some of the facts of modern Indian life. Moreover, in order to make sense of the problem of HIV/AIDS among Native Americans, some stereotypes must be laid to rest and the reader must be given a contextual framework within which to place such information.

The Impact of Stereotypes On Indian Life

The realities of Indian life have been obscured due to centuries of multilayered stereotypes which continue to confound understanding and communication. Vine DeLoria put it succinctly when he said: "People can tell just by looking at us what we want, what should be done to help us, how we feel, and what a 'real' Indian is really like...To be an Indian in modern American society is in a very real sense to be unreal and ahistorical."[1]

Unfortunately, the cigar store, befeathered Indian caricature is still considered acceptable by a majority of non-Indians: for example, it still serves as a mascot for football teams, and it is still used as a model for dressing young children in costumes on Halloween. It is difficult for non-Indians to understand how irritating, depressing, and destructive this type of stereotyping is, and how little it represents the Indian cultures of today.

It is especially damaging to younger Indians, who are struggling with their identities. Try to imagine and understand what it would be like, when one is in school, in one's country of origin, to have one's own history and culture ignored — or, at best, mentioned only in passing. Or, what it would be like, as an adult or young person *never* to be treated as a real person — and to have non-Indian people constantly invalidating your identity because you do not fit their stereotypes. Such behavior toward Indians — as true today as it ever was — is part of what we mean when we speak of "cultural genocide." When these stereotypes get in the way of health professionals providing education, prevention, surveillance, and information, the results can be tragic.

The number and sheer depth of stereotypes about Indians create stress and anxiety for many Native Americans. These stereotypes also create barriers in acknowledging the existence of AIDS in our communities, and in recognizing individuals who have AIDS for AIDS case surveillance.

> *"The number, and sheer depth, of stereotypes about American Indians create stress and anxiety for many Native Americans... At the root of such stereotypes is the mistaken view that we are one people. Like Europeans, Native Americans are not one people."*

We Are Not One People

At the root of such stereotypes is the mistaken view that we are *one* people. Like Europeans, Native Americans are not one people, although our experiences with the outside world have helped to create a pan-Indian identity. One's tribe (nation) — Choctaw, Peoria, Tlingit, Malecite, Arikara, Okanagan, Snohomish, Caddo — is where one's primary ethnic identity lies. Each tribe has developed its own language, customs, and beliefs; each has had a different history; and each has exercised its own strategy for dealing with the relentless invasion of new peoples and with the catastrophic changes that have taken place in their traditional lifestyles.

How We Are Labeled by Others and By Ourselves

All Native Americans, in our languages, are and always have been "the people." But, among most of us today, "Indian" is the most common term used when we talk with one another in English. Nonetheless, it is important to understand that, until the Europeans arrived and thought they had come upon India, among the indigenous population there were no so-called Indians.

Several terms will be used in this article, interchangeably, for the aboriginal inhabitants of North America, none of which is at all, or entirely, accurate, though all of which have been accepted in American English to some degree or another. "Native American" and "Indian"

will be used in order to avoid the cumbersome and lengthy expression, "American Indian/Alaskan Native," which has several meanings: racial, ethnic, and legal.

The definition of who is, or who is not, an American Indian or Alaskan Native, depends on who is doing the defining. But, in the most general sense, these are individuals who are recognized by an aboriginal nation of North America as citizens of that nation. However, each nation or tribe exercises its sovereignty by defining who its citizens are, and there are no standard rules for what determines tribal citizenship. For example, some tribes require that individuals have a particular blood quantum (see box below); some that their mother is a member of the tribe; and some that they be descended from a base roll of tribal members at a particular point in time.

Congress occasionally has established its own eligibility requirements for specific federal programs for Indians, and the U.S. Census has relied on an individual's own perception of his or her ethnicity. "Federally recognized" American Indians or Alaskan Natives are tribally-recognized citizens of the original nations of North America that have maintained a government-to-government relationship with the United States. Since 1924, Indians have been dual citizens: citizens of the United States, and citizens of the aboriginal nation to which they belong.

We Are of Mixed Racial Descent

The majority of Native Americans are of mixed racial descent. In 1910, a special census of the American Indian population found that 35.2% of the Indian population at that time were of mixed racial descent.[2] By the 1930 census, 42.4% were "mixed-bloods." Moreover, the number of mixed-bloods varied by tribe. For example, among the Ojibwe (in 1930) only 18.7% were "full-bloods," while among the Pima 97.9% were full-bloods. In 1985, the U.S. Bureau of the Census reported that more than one-half of all American Indian men and women were marrying non-Indians.[3] Mixed racial descent leads to underreporting in case surveillance. For example, an Office of Technology Assessment report on Indian health (1986) stated that ethnic misidentification was the most important limitation on available mortality data.[4]

Such difficulties have led researchers to believe that there is underreporting of AIDS cases to, and by, the Centers for Disease Control (CDC) in respect to this community.[5] Most case surveillance relies upon the diagnosing physician's report of an individual's ethnicity. The original information may or may not have come from the patient directly. In cases where a physician relies upon skin color or other racial features or on the last name, mistakes occur; it is not always easy to tell by sight or by name, who is or is not Indian. Native Americans, as a group, do not always fit the stereotypical racial characteristics expected by most non-Indians. It has been my experience that even Native Americans who are not of mixed-race often are misidentified as Filipino or Chinese. Also, many Indian people in the Southwest and California have Hispanic last names, and in the state of Washington many coastal Indians have intermarried with Filipinos. The solution to the problem is to encourage Indian people always to report that they are Indian, and to encourage service providers to *ask* before assuming a person's ethnicity.

We Are Invisible in Our Own Land

We are invisible in our own land. Many Americans are surprised that AIDS is a problem for our people — or even that we still exist. The realities of contemporary American Indian life are unknown to the vast majority of Americans, partly due to our small population. Since the initial European invasion of North America, epidemics of diseases over the centuries — including smallpox (perhaps the biggest killer), diphtheria, typhoid, cholera, syphilis, typhus, and alcoholism — against which Indians

"CERTIFICATES OF DEGREE OF INDIAN BLOOD"

In this late twentieth century, American Indians and Alaskan Natives are still being issued identity cards called "Certificates of Degree of Indian Blood" (CDIBs) by the U.S. government. These purport to "document" the amount of blood that an individual contains (here, a nonliquid measure) of an aboriginal tribe (1/2, 1/3, 1/32 and even 1/1024 Cherokee or Creek, for example), as if it were possible for this to be an accurate measurement of ethnicity.

A common question now faced by an Indian person who is of mixed race is: "How much Indian blood are you?" It is curious why such a question is not automatically asked of the Irish, German, Italian, or Polish Americans, or indeed of any other ethnic group in this country.

Only black ethnicity was measured at one time by "blood" in Louisiana (it was measured in quadroons and octoroons, etc.), presumably to insure that no one with any black ancestry would taint the white bloodline of the inhabitants. Any attempt to resurrect this nonsense with blacks today would be met, I am sure, with extreme reactions.

Why then do such certificates continue to exist for American Indians and Alaskan Natives? Where else does such a system exist? And what cultural assumptions and scientific facts underly their persistent use?

Our ethnic identity includes our communities, histories, memories, traditions, rituals, and kinship, which cannot be found in a blood quantum.

have had no immunity, have cost the lives of millions. A recent study of the history of epidemics among American Indians and Alaskan Natives estimates that approximately 500,000 North American aboriginals lost their lives each century from 1492 until 1900, the aboriginal population nadir.[6]

We as Native people have come close to extinction as a human community, and we are very conscious of that fact. Try to imagine a world without the benefit of the richness of our cultures, our experiences, and our presence. We have greatly contributed to the survival and growth of the American people, our country, and as far as that goes, the world. To illustrate what I mean: several years ago, I visited Romania, where I was presented with a meal of the Romanian national dish, *mamaliga,* a corn mush. It never occurred to my hosts that domesticated corn was a gift from aboriginal America to the Europeans. When most people think of potatoes, a staple in the European diet, they think of the Irish, even though potatoes were brought to the Irish from aboriginal America. My tribe, the Choctaw, even donated to the Irish Relief during the potato famine.

During the 20th Century, the Indian population grew substantially, from 100,000 to more than 1.5-1.7 million self-identified people of aboriginal descent, and to somewhat less than 900,000 legally-recognized tribal citizens. Nonetheless, Native Americans still make up less than 1% of the total U.S. population.

Not All Indians Reside On Reservations

When most people think of Native Americans, "reservation" is usually one of the first words that pops into their minds. In fact, only one out of four Native Americans resides on a reservation.[7]

Many Americans are unaware, for example, that what is now the state of Oklahoma was, prior to 1890, Indian Territory (not a true territory in the sense that Puerto Rico is a territory, but the location of small Indian republics). This territory was used, from the time of the purchase of Louisiana from France until the 1870s, as a relocation center for tribes driven from their homes in every region of the United States. The territory was originally granted by the U.S. to the so-called Five Civilized Tribes of the Southeast, with legal titles issued by the President of the U.S. After the Civil War, the Western lands of these tribes were taken and used for concentrating other tribes driven from their homes by the U.S. Army. Although the tribes of the Southeast had been forced to exchange their ancient homes for new land beyond the Mississippi, it came as a shock that, within one generation, the U.S. even took that away when in 1907 the state of Oklahoma was created. It may be of interest to note that, in 1906, the Five Civilized Tribes came within one vote in Congress of creating a separate Indian state called Sequoyah.

Oklahoma now has the second largest Indian population of any state. It, like California, the state with the largest population of Indians, is not a reservation state. In California, nine out of ten Native Americans live in urban areas;[8] there are only two sizeable reservations and a number of tiny rancherias. Also, the bulk of the state's Indian population has come from other states.

Reservations, which can be found from Maine to Alaska, are an important fact of Indian life and are unique to us — a few, in fact, are larger than some states (for example, the Navajo, which covers territory in four states) — but they tell only part of our story.

The myth that Indians live only on reservations contributes to the lack of visibility of the majority of Indians who live in cities or in nonreservation rural settings, and thus to problems with HIV seroprevalence data, AIDS case surveillance, and resource allocation.

HIV/AIDS in Native American Communities

As of January 1990, 159 diagnosed cases of AIDS among American Indians, Alaskan Natives, and Native Hawaiians had been reported and verified by the CDC.[9] The Indian Health Service (IHS) and the CDC have just begun to undertake a seroprevalence survey of Native Americans nationwide. The purpose of this study is specifically to determine the extent of HIV infection in both rural and urban American Indian/Alaskan Natives communities. Results from this study are expected sometime in 1990.

AIDS cases have been reported among Native Americans in every region of the country, among both men and women, and from almost every age category; only ages 5 to 12 are not represented in the reported cases of AIDS, although there is a recent unofficial and unconfirmed report of a nine year old who was infected through sexual abuse. In comparison with the number of AIDS cases among whites, blacks, and Hispanics, these numbers may seem quite low. However, it is important to note that there are other sources of seroprevalence data, namely the Military Recruit Study and the Sentinel Hospital Study, that show American Indians/Alaskan Natives with higher rates of seropositivity than what one would expect from the number of reported cases.[10] In California, the seropositivity rate for American Indians/Alaskan Natives in the Military Recruit Study is 4.4/1,000 second only to, and almost tied with, blacks.[11] Compared to whites, relatively fewer men were infected through homosexual sexual behaviors, and relatively more were infected through IV drug use (though a portion of the IV drug users were also men who have had sexual intercourse with men).[12]

Because of misperceptions among non-Native Americans, efforts to inform Native American communities about the risk of HIV/AIDS, and how to prevent the virus from spreading, were relatively late in getting off the ground. Indian people were forced to take matters into their own hands when it became apparent that the government, health professionals, and AIDS activists of all kinds did not consider Native Americans at risk — or even consider them at all. Unfortunately, it was initially difficult for otherwise responsible people to believe that Indian people could be endangered by AIDS, in spite of acknowledged high rates of syphilis, gonorrhea, chlamydia, and substance abuse among our people.

Because of stereotyping, Native American people have not been acknowledged as being sexual in the

same way as the rest of humanity. For example, the suggestion that there were Indian people with same-gender or bisexual orientation was considered shocking. However, in the past three years, at least two major books have been published on traditional and contemporary bisexuality and homosexuality among American Indians.[13, 14] The books provide convincing evidence that many tribes have included a traditional social role for homosexual men; little has been written about women who are homosexual, which may be due to the fact that writers on the subject have been European men. Although many of our traditional attitudes have changed under the influence of Christian missionaries and general European culture, they have not entirely disappeared. As Lame Deer put it, "To us a man is what nature, or his dreams, makes him. We accept him for what he wants to be. That's up to him..."[15]

To a somewhat lesser extent, the same attitude and response has marked reactions to the use of IV drugs. Although most people associate alcohol abuse with Indian people — and there is a modicum of research on the subject — little has been known or written about Native Americans and the use of IV drugs, such as methamphetamines ("poor man's cocaine"), cocaine, and heroin, for example. Moreover, intravenous drug use is generally associated with cities (where Indians are not Indians according to some government officials) and is not considered an issue for the more isolated, rural Indian people. The reaction of some health professionals working with Indians has simply been to assume that IV drug use does not happen, rather than to thoroughly investigate the issue. The evidence that does exist points to a problem — at least in some communities.[16]

Indian Health Status and the Role of the Federal Government

A common misperception is that the federal Indian Health Service (IHS) takes care of the health needs of Indian people, and that Indian people receive generous benefits from the U.S. government. Attention to the need for HIV prevention education for Native Americans was delayed among states and other federal bureaucracies, partially because of the mistaken perception that the Indian Health Service would "take care of them."

The IHS is a poorly funded, small agency in a huge health bureaucracy that is unable to provide medical services for even one-half of the Indian population. For the past several years, the IHS has attempted to restrict its services to an even smaller proportion of the Indian population, but has not been successful. For example, three years ago the IHS published proposed regulations in the *Federal Register* to limit its services only to Indian individuals with one-quarter blood quantum or more of a particular tribe. Although the proposed regulations did not go into effect — due to the virtually unanimous Indian opposition and the intervention of Congress — the search for ways to serve only a few Indian people has continued. In spite of the fact that the majority of Indian people live in urban areas, urban Indian health programs have faced over the past several years an ongoing effort by the Executive Branch of the government to take away their funding support.

Even the medical care available to the few eligible Indian people has been severely restricted. An example of this is the fact that in 1984 per capita annual expenditures for contract care (the care mainly provided by sec-

RESOURCES DESIGNED FOR NATIVE AMERICAN COMMUNITIES

WE OWE IT TO OURSELVES AND TO OUR CHILDREN, an awardwinning health education publication designed especially for Native American communities, is a booklet of traditional poetry, Native American stories, and images. Focus group testing showed that Native Americans felt embarrassed by most materials on STDs. To diffuse the embarrassment associated with STDs, this book was designed to be subtle, beautiful, and informative, in order to effectively teach individuals in small group settings about sexually transmitted disease (STD) prevention and treatment, including condom use.

Grandmother Spider
Wove the world out of Herself
Silvery strands of color
connecting all
weaving webs of generations
and regenerations

(This excerpt from the book is accompanied by a photograph speaking of the strength of a Yuma mother, holding a child on her lap.)

The images and legends appeal to individuals to think not only of themselves, but of the family, and of the generations to follow. They reflect the Native American tradition of being connected to the group, the tribe, and the family, and also reflect the reality that STDs are not an individual problem, but one of relationships and of society. The publication demonstrates that it is possible to present a number of messages, combine traditional Native American approaches with government health guidelines, and still speak to the reader with sensitivity and respect. $5.

WE OWE IT TO OURSELVES AND TO OUR CHILDREN: THE VIDEO uses cartoons from *Understanding STDs* and *Understanding AIDS and HIV* to illustrate the causes, symptoms, treatment, and prevention of AIDS and STDs. 8 mins. $35.

UNDERSTANDING STDS is a *storytelling packet that consists of 25 separate cartoons* illustrating the treatment and prevention of STDs. Each 8½x11 cartoon comes with text. Includes a facilitator's guide, with instructions for making handouts, transparencies, and slides for group presentations. $5.

UNDERSTANDING AIDS AND HIV, a companion piece to *Understanding STDs*, is a *storytelling packet that consists of 25 separate cartoons* illustrating the treatment and prevention of HIV infection and AIDS. Each 8½x11 cartoon comes with text. Includes a facilitator's guide with instructions for making handouts, transparencies, and slides for group presentations. $5.

CIRCLE OF WARRIORS, a *video* (produced by the Alaska Native Health Board, in conjunction with the Seattle Indian Health Board and NNAAPC, and dedicated to the memory of Ray Harjo) featuring nine Native American adults and one child who are living with HIV/AIDS. They discuss sexuality, health, discrimination, and family. 27 mins. $75.

FACE TO FACE, a *video* (produced by the Alaska Native Health Board, in conjuction with the Seattle Indian Health Board and NNAAPC, and dedicated to the memory of Ray Harjo) is composed of five extended interviews with Native Americans living AIDS who discuss various aspects of their lives, including health, sexuality, testing, childrearing, and discrimintion. Discussion guide included. 47 mins. $100.

AIDS: THE BASICS. A MANUAL FOR NATIVE AMERICAN HEALTH AND HUMAN SERVICE WORKERS — developed by Ron Rowell, MPH (Choctaw/Kaskaskia), Terry Tafoya, PhD (Taos Pueblo/Warm Springs), and Corinne Axelrod, MPH, (California Rural Indian Health Board) — covers: AIDS and substance abuse, STDs, attitudes, beliefs and psychosocial issues, traditional Native American medicine and AIDS, training, and target groups. Includes a sample needs assessment, a lesson guide, sample pre- and posttests, and other methods of evaluation, references, statistics, and a glossary. $5.

SEASONS, a *quarterly publication* of NNAAPC, contains information about AIDS and HIV infection, HIV prevention, models for education, and updates on treatments, grants, and training. Free.

INDIAN AIDS HOTLINE: 800/283-AIDS

For more information contact the National Native American AIDS Prevention Center, 6239 College Avenue, Suite 201, Oakland, CA 94618, 415/658-2051.

ondary and tertiary care centers outside of IHS, but paid for by IHS) ranged from $7.33 in California to $473.15 in Montana and Wyoming.[17] If you live, as I do, in an area where it is difficult to buy even one lunch or dinner for $7.33, or if you are familiar with the cost of a one-day stay in an average hospital, you will understand the quantity and quality of the health care that these funds purchase. When IHS has no funds to purchase AZT or aerosol pentamidine, for example, Indians with HIV infection may go without life-enhancing treatments. Physicians and health activists are now discussing the concept of "rationed care" for the general population, but for American Indians such care has been a way of life for decades.

A few years ago, the IHS budget was slashed by several million and the funds were transferred to the National Institutes of Health under pressure for increased government funding for AIDS. That money was never replaced, nor were the funds used to establish HIV prevention programs in American Indian communities.

> *"...the health status of Indian people is still poorer that that of the general U.S. population, on almost every health indicator."*

In a system in which public funds are allocated on the basis of clout, either in numbers or due to a high degree of political organization, American Indians have had neither. Moreover, there has been little public support for continuing to provide Native Americans with the services promised in the past, and virtually no understanding that the minimal services that are provided were bought at a very high price. If one combines the lack of understanding among most Americans of the contracts their ancestors originally made with the native peoples of this land, along with the small Native American population, any attempt to improve the health of our people or to guarantee our rights under solemn agreements becomes extremely difficult, in almost all circumstances.

It should therefore not be surprising that the health status of Indian people is still poorer that that of the general U.S. population on almost every health indicator.[18] Thirty-seven percent of Native American people die before the age of 45. In 1985, of the top 10 causes of mortality, four were directly caused by substance abuse, and the majority, if not all the rest, can be viewed as indirectly related. Infant mortality rates among Native Americans have improved considerably since the mid-1950s, but these rates still exceed those of all other races in the U.S., largely due to death in post-neonates.[19]

Outreach in Native American Communities

Although we might wish that AIDS education outreach efforts had been begun earlier, having been forced to organize our own efforts has not been without its benefits. This new challenge has reminded us of the elements of our culture that have allowed us to survive, in spite of everything that has happened, and to apply what we have learned in working with the AIDS epidemic. For example, our cultures' common values — respect for our elders, teaching our children survival skills, focusing on the extended family, strong spiritual traditions, storytelling and humor — all have helped us to

Traditional Medicine People Gather To Talk About AIDS

A special "Gathering for Traditional Medicine People and Healers to Talk About AIDS," is now sponsored annually in California by the Native American AIDS Advisory Board. Close to 200 people attended the last gathering, representing more than 33 tribes from throughout the state, to obtain information about AIDS, to discuss HIV/AIDS among Indian people, and to learn how traditional Native American practices, including the use of medicines and herbs, can be effectively used to help prevent and treat HIV/AIDS and other health problems, such as alcohol and drug abuse, in Native American communities. The three-day event has included traditional Native American ceremonies, sweats, and dancing.

Further information on these gatherings can be obtained by contacting Larry Murillo, Project Director, Native American AIDS Education and Prevention Program, California Rural Indian Health Board, 2020 Hurley Way, Suite 155, Sacramento, CA 95825, 916/929-9761.

design educational strategies that work for our communities. Traditional Native American healers have been quick to respond to the epidemic and traditional healing practices, many of which are preventive in nature, are being used. Indian people with AIDS have chosen to involve both traditional and Western medicine in their treatment plans. Also, Indian artists and musicians have worked on the design of materials. The AIDS prevention effort has become a force in the broader movement of self-determination for Native American people.

Indian communities have come together, and they have begun to organize. There are now locally-based, regional and national Indian AIDS prevention education efforts, both funded and nonfunded.

The National Native American AIDS Prevention Center (NNAAPC) in Oakland, California was funded by the U.S. Centers for Disease Control in 1988 to assist locally-based and regional efforts with training and technical assistance. NNAAPC is an Indian governed and managed private nonprofit organization. The agency operates a national toll-free Indian AIDS Hotline and a clearinghouse for Native American-targeted, AIDS-related, health education materials, and provides information services to clients, including distribution of a quarterly newsletter, *Seasons*. The National Indian AIDS Media Consortium, also funded by the CDC, is a NNAAPC cooperative project with the Native American Press Association that provides ongoing information to Indian newspapers and radio and television stations about HIV/AIDS, in order to encourage regular reporting on the issue.

Another national organization, the American Indian Health Care Association of St. Paul, Minnesota is also funded by the Centers for Disease Control to produce Native American-targeted health education materials and to assist its urban Indian clinic members.

In some states, Washington, for example, the Seattle Indian Health Board has joined forces with other people of color to insure that resources are made available for Native American projects. In Minnesota, the Minnesota American Indian AIDS Task Force has done an outstanding job of organizing both urban and reservation communities, and is working cooperatively with a wide range of agencies and organizations. The Alaska Native Health Board has worked long and hard to reach isolated communities by utilizing new communications technologies and by producing excellent educational materials. In Arizona, the Inter-Tribal Council of Arizona has organized reservation-based AIDS prevention activities. In Phoenix, the urban Indian clinic has begun an outreach program to gay and bisexual Indian men and is working closely with

> *"Our struggle is — as it has been for so long — a struggle for survival as a people. We are not being alarmist when we raise the potential of another demographic collapse due to AIDS and the disappearance of entire indigenous cultures. An epidemic which primarily affects those individuals in their most fecund years can destroy a tribe's future. It has happened before in our history and it can happen again. However, we are tough and we are determined. We will survive the AIDS challenge. We have 30,000 years of experience in America to help us do so."*

the Arizona Department of Health. In California, San Francisco's American Indian AIDS Institute has developed AIDS educational materials for Indian men and for teens and has provided training to local Indian agencies, and the Native American Health Board of Oakland has begun a Youth Empowerment Project to train Indian teens as peer counselors. In Oklahoma, the Intertribal AIDS Task Force and Oklahoma City's urban Indian clinic have been working hard to get the word out and to support Indian people with AIDS. In South Dakota, the Native American Women's Health Education Resource Center has begun organizing a statewide Indian AIDS Task Force, with participation from most of the reservations in that state. In Maine, the Penobscots and Passamaquoddies have established community-wide AIDS task forces and have held town hall meetings.

This is by no means an exhaustive list of AIDS activities in Indian country, but as you can see, Indian people have responded vigorously to the challenge posed by AIDS. *We know an enemy when we see one.*

Conclusion

Most Indians realize that AIDS cannot be divorced from other major health problems. They are all connected, and we must enable others to see these connections. There are many ways to approach HIV/AIDS prevention, but STD control and substance abuse prevention and intervention are the most obvious. The purpose of HIV/AIDS prevention education is to change behaviors that place individuals at risk. If we succeed in changing the sexual and substance abusing behaviors at the root of HIV transmission, we will also succeed in preventing other major problems like Fetal Alcohol Syndrome, STDs, chronic liver disease, and the majority of accidents, homicides, and suicides that occur among Native Americans. We must use every avenue open to us.

Our struggle is — as it has been for so long — a struggle for surival as a people. We are not being alarmist when we raise the potential of another demographic collapse due to HIV/AIDS and the disappearance of entire indigenous cultures. An epidemic which primarily affects individuals in their most fecund years can destroy a tribe's future. It has happened before in our history and it can happen again. However, we are tough and we are determined. We will survive the AIDS challenge. We have 30,000 years of experience in America to help us do so.

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This issue of the *SIECUS Report* was produced in cooperation with the Centers for Disease Control, Cooperative agreement # U62 CCU 2011 28-01. SIECUS is grateful to the Review Committee for their comments and suggestions: Antonio Burr, PhD, senior psychologist at St. Mary Hospital Community Mental Health Center; Maureen Corry, deputy director of community services, March of Dimes Birth Defects Foundation; Father Patrick McGovern, associate pastor of Our Lady of Fatima Parish; Rodger McFarlane, executive director of Broadway Cares, Inc.; Ron Moglia, EdD, director of the Human Sexuality Program (SEHNAP), New York University; and Catherine Smith, MPH, director of Family Life Education Projects, Girls Clubs of America.

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Catholic Charities USA

CATHOLIC CHARITIES USA
FACT SHEET

Rev. Fred Kammer, SJ
President

Description

Catholic Charities USA is the nation's largest private network of voluntary social service agencies. In all, over 1,400 local agencies with more than 265,000 staff members and volunteers serve people in need – mostly families and children – more than 12 million times a year. In 1991, Catholic Charities agencies across the United States spent $1.8 billion; about 87 percent of agency budgets are allocated to program expenses.

Services

Catholic Charities agencies provide direct services to people in need, with an emphasis on enabling them to achieve self-sufficiency. Agency staff members help people overcome addiction as well as give support to homeless families who have nowhere else to go. Other services include:

- Food
- Emergency shelter
- Emergency financial assistance
- Housing assistance
- Counseling
- Treatment for misuse of alcohol and other drugs
- Pregnancy counseling
- Adoption
- Services to persons with HIV/AIDS
- Refugee and immigration assistance
- Education and job training
- Out-of-home care

In addition, Catholic Charities agencies focus on:

- *Legislation* (in the areas of housing, economic initiatives, child care)
- *Community organizing* (housing, economic initiatives, hunger)
- *Advocacy* (legal assistance for homeless people, refugees, people with HIV/AIDS, substance abusers, families and children)

National office

Catholic Charities USA is a membership organization founded as the National Conference of Catholic Charities in 1910. By providing leadership, technical assistance, management training, and resource development, the national office enables local agencies to better devote their own resources to serving their communities. Catholic Charities USA seeks to develop and promote innovative strategies that address human needs and social injustices.

President

Rev. Fred Kammer, SJ

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Catholic Charities USA

1991 Annual Survey

Service and Advocacy

In 1991, some 12.3 million people across the United States turned to Catholic Charities agencies. That includes 8.4 million people facing a crisis – no food or shelter, for example – and another 3.9 million people seeking social services such as counseling, day care, and housing.

Catholic Charities USA is the organization that unites the social service agencies operated by most Catholic dioceses in the United States. This network of more than 1,400 agencies and institutions, plus thousands of volunteers and staff members, aims to support families, strengthen communities, and reduce poverty. Besides assisting people of all religious, ethnic, social, and economic backgrounds, Catholic Charities strives to address the root causes of poverty and social injustice. The national office joins local agencies in addressing the major social concerns of the day, such as problems related to alcohol and other drugs, homelessness, and aging.

Catholic Charities agencies respond to the needs of families and individuals by providing a wide range of support services. In addition, social action efforts such as advocacy and public policy development are a top priority as agencies work to change unjust social structures and institutions.

Marked increase in emergency services

When the 1991 survey is compared to 1981, we find drastic increases in the number of people receiving social services as well as the number who need emergency help. In 1991, some 12.3 million individuals received social and emergency services, compared to 3.4 million in 1981. This 258 percent increase occurred mostly in emergency services.

Social Services

More than 1.3 million children and adolescents, 1.9 million adults, and 500,000 elderly people turned to Catholic Charities for social services in 1991.

- **Counseling: 700,000 people.**
  For problems such as alcoholism, drug abuse, employment, family dysfunction, and housing.
- **Pregnancy, adoption services: 100,000 people.**
  Includes 3,178 adoptions (1,202 children with special needs and 389 international). Nearly 43,500 pregnant women and 6,500 birth fathers received pre- and post-natal care, housing and material assistance, pregnancy counseling, and education.
- **Housing: 111,600 people.**
  Housing units for the elderly, disabled people, and families as well as single-room occupancy units.
- **Out-of-home services: 118,500 people.**
  Foster care, group homes, and residential care facilities.
- **Services to refugees and immigrants: 273,900 people.**
  Education, employment, housing, and legal services.
- **Preventive and support services: 2 million people.**
  Family life education, day care for adults and children, respite and hospice care, neighborhood and senior socialization.

Emergency Services

Because it's difficult to count the number of people who receive emergency services such as food, shelter, and financial assistance, these were separated from social services in the 1991 survey. We asked agencies to give their best estimates.

Food: 2.1 million people
About 2.1 million people were served by agencies in 206 soup kitchens. Another **4.7 million people** received food through food banks, distribution programs, and Meals-on-Wheels.

Shelters: 93,000 people
More than 93,000 people were sheltered, and nearly 4,700 homeless people received transitional housing services. Agencies sponsor or manage 233 emergency shelters with nearly 9,000 beds.

Emergency/crisis services: 1.5 million people
One million people received emergency financial assistance, 381,300 received emergency clothing, and another 65,500 found emergency medication assistance. About 30,000 people sought emergency services after crises such as physical or sexual abuse, disasters, and running away from home.

Other services

Alcohol, other drugs: 45,025 people
About 45,025 individuals participated in treatment programs. Besides providing direct services, Catholic Charities agencies seek to prevent the abuse of alcohol and other drugs through education and community involvement.

HIV/AIDS: 14,000 people
Nearly 14,000 persons with HIV/AIDS received counseling, social service referral, emergency financial assistance, residential care, outpatient medical care, and legal assistance.

Disaster response: 11,600 people
About 11,600 people were helped by the 32 agencies that engaged in disaster relief services in 1991.

Child day care: 33,000 children
Nearly 33,000 children went to Catholic Charities for day care; two-thirds of them came from families with low incomes.

Social action

Catholic Charities seeks to address the causes of problems which lead to the need for social services.

Agencies' top five **advocacy efforts** focused on homeless people, pregnant teenagers, people with HIV/AIDS, people who need health care, and refugees, immigrants, and migrants.

Agency **legislative action** (national) focused on economic issues, family life (including child care, adoption), health care and insurance, hunger and nutrition, and international justice and refugees.

Community organization (done by more than two-thirds of the Catholic Charities agencies) revolved around family life, hunger and nutrition, economic issues, housing, and health care and insurance.

Parish social ministry programs, which aim to involve parishioners in helping their neighbors in need, were undertaken by more than 60 percent of the agencies. Those who received social services most often in the parish context were people who are grieving; refugees, immigrants, and migrants; elderly people who are homebound; women who have had abortions; and people with addictions.

Personnel

Across the United States, 264,659 people worked for Catholic Charities during 1991, nearly three-fourths of them volunteers. The remaining include 56,388 paid staff members and 16,502 people who served on corporate and advisory boards.

Catholic Charities USA

1991 Annual Survey • Income and Expenses

Expenses 1991*

	Amount	% of total expenses
Program Expenses	$1,526,569,326	87.1%
Overhead	214,379,042	12.2
Public Relations/Fund Raising	12,063,426	0.7
Total spending	**$1,753,011,794**	**100%**

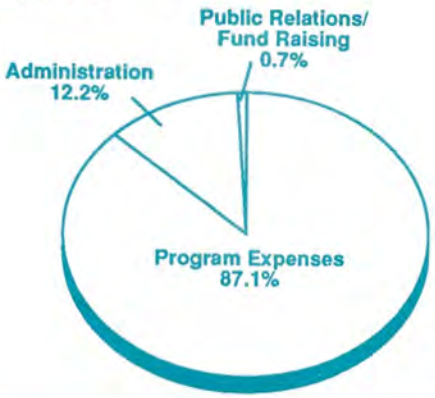
Income 1991*

Cash and in-kind	Amount	% of total income (including in-kind)
Government Includes federal, state, and local government funds for purchase of services for out-of-home and day care of children, FEMA, and other program grants such as substance abuse and family preservation services.	**$1,159,710,437**	**62.9%**
Program Fees Includes direct client and third-party payments	**259,012,738**	**14.1**
Church Includes Catholic Charities appeal, other fund raisers, investment income, and other contributions.	**203,117,026**	**11.0**
United Way	**97,941,759**	**5.3**
Grants	**15,918,430**	**0.9**
Other	**55,599,967**	**3.0**
Cash income	**$1,791,300,357**	**97.2**
In-Kind Includes staff time, overhead, and other services	**51,300,825**	**2.8**
Total Income	**$1,842,601,182**	**100%**

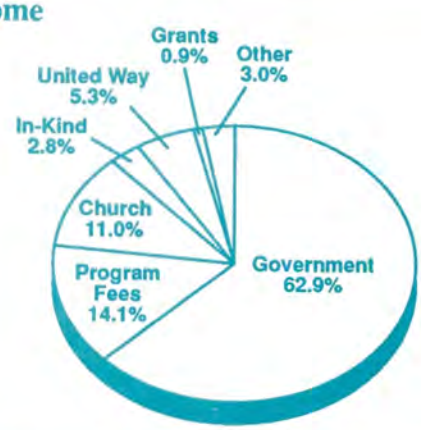
* A minority of agencies did not fully itemize expenses and/or income. These "unspecified" entries were divided into the listed categories according to the spending or income patterns of agencies that did specify expenditures and income sources.

Upon request, audited data are available for the national office of Catholic Charities USA, a 501(c)3 organization. Individual local agencies keep their own financial data.

1991 Expenses



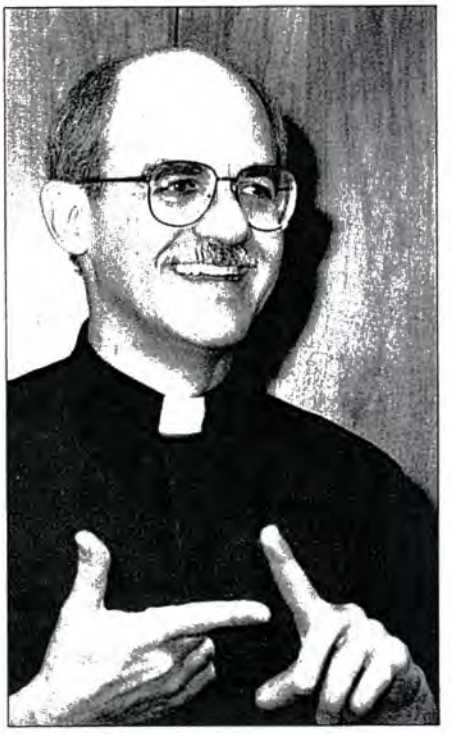
1991 Income



This information is from Catholic Charities USA's 1991 Annual Survey of Diocesan Agencies. Each year, the national office collects information on spending and services rendered by local Catholic Charities agencies across the United States, resulting in the only national picture of Catholic Charities activities.

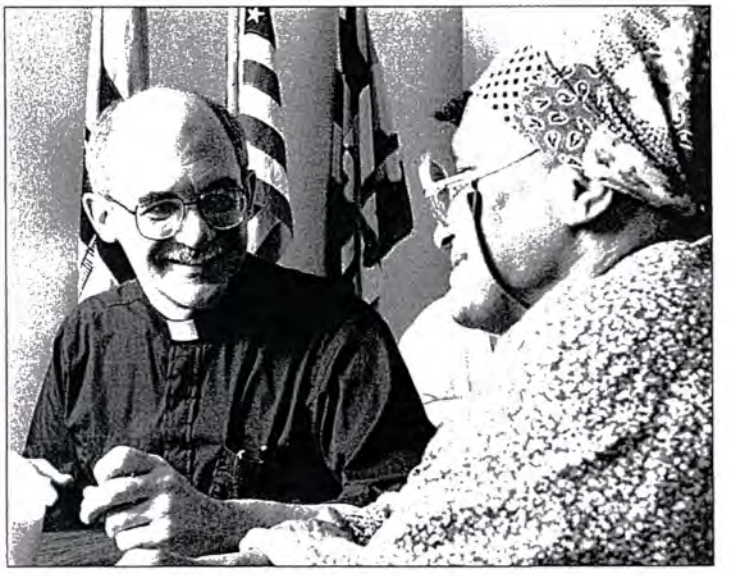
For 1991, 154 of the 163 U.S. dioceses which offer social services through Catholic Charities agencies responded to the survey. The response rate was 94.5 percent. Please see complete survey for more details.

FRED KAMMER, SJ
President, Catholic Charities USA



Fred Kammer, SJ, is an attorney, author, educator, and priest. A stimulating thinker, Father Kammer encourages leaders in government and business to empower families and communities to be productive and caring.

As president of Catholic Charities USA, the country's largest human service organization, Father Kammer understands the complex social challenges facing the nation. From his many years of direct experience as a community leader, social policy analyst, advocate, and volunteer, he brings a refreshing insight for identifying problems and finding collaborative solutions.



Credentials: Alfred Charles Kammer, SJ

Author, *Doing Faithjustice: An Introduction to Catholic Social Thought*

Director, Senior Citizens Law Project, Atlanta Legal Aid Society

Visiting Scholar, Woodstock Theological Center, Georgetown University

Policy Advisor on Health and Welfare, United States Catholic Conference

Executive Director, Catholic Community Services, Baton Rouge, LA

Lawyers' Committee for Civil Rights Under Law, Chicago

Founding Chair, Jesuit Volunteer Corps, South

Atlanta Regional Commission Task Force on Aging

Board of Trustees, Loyola University of New Orleans

Leadership Greater Baton Rouge

National Health Policy Reform Task Force, Catholic Health Association

Who's Who in American Law

Yale Law School, J.D.

Loyola University of Chicago, M.Div.

Contact: Catholic Charities USA
1731 King Street.
Alexandria,VA 22314
(703) 549-1390, Ext. 13

Your future
is in
the hopes
of the
poorest people
in the country:

OUR CHILDREN

What are you going to do about it?

Fred Kammer, SJ, speaks out on children, families, communities.
For the common good.

Catholic Charities USA
1731 King Street
Alexandria, VA 22314
Phone (703) 549-1390, Ext. 13

THE Feminization OF POVERTY

Look at me
I am the new homeless.
My face is poverty.
My name is Female.

Have you any education,
Job training,
Full employment,
Promotions,
Health care,
Day care,
Insurance,
Retirement?

Look at me.
I am homemaker,
Single parent,
Widow,
Unemployed teen,
The low-wage labor
force,
Mother, sister, daughter, wife,
insignificant other.

Look at me,
My face is poverty,
My name is Female.

The feminization of poverty.
Together, we can beat this.
It's just economics.

Fred Kammer, SJ, speaks out on the feminization of poverty for Catholic Charities USA.
Phone: (703) 549-1390, Ext. 13
Write: 1731 King Street, Alexandria, VA 22314

Catholic Charities USA

Catholic Charities USA HIV/AIDS Committee

Goals:

1. Develop a profile of services provided by Catholic Charities USA member agencies to persons with HIV/AIDS.
2. Provide consultation services to member agencies requesting assistance in developing programs for persons with HIV/AIDS.
3. Make available materials/opportunities for education of staffs about HIV.
4. Study the needs of persons with HIV/AIDS in conjunction with the Centers for Disease Control (CDC).
5. Develop a model agency policy on serving persons with HIV/AIDS.
6. Collaborate with other organizations around HIV, especially Catholic Health Association, National Catholic AIDS Network and AIDS National Interfaith Network

Members - Catholic Charities HIV/AIDS Committee

Rev. James Schexnayder, Chair
Catholic Charities, HIV/AIDS Srvs.
433 Jefferson Street
Oakland, CA. 94607
(510) 834-5657, ext. 3114

Ms. Colleen Gallagher
Catholic Charities-Pro-Life Ofc.
Cleveland, OH
(216) 696-6525, ext. 392

Rev. Charles McCarron
Catholic Charities - HIV/AIDS Srvs.
Amityville, NY 11701
(516) 789-5206

Ms. Bonnie Verona
801 rue de Burgundy - #213
New Orleans, LA 70005-4621
(504) 523-3755 - Residence

Rev. Bruce Cwiekowski
Catholic Charities HIV/AIDS Pgm.
2838 East Burnside
Portland, OR 97214
(503) 233-8379/234-2545

Rev. Robert J. Vitillo
Caritas Internationalis
Palazza San Calisto
V-00120 Vatican City
(011-39-6) 698-7197

Ms. Rosemary Winder Strange, Staff
Catholic Charities USA
1731 King Street
Alexandria, VA 22314
(703) 549-1390 ext. 27

1731 King
Street •
Suite 200 •
Alexandria
Virginia
22314 •
Phone:
(703) 549-1390
Fax:
(703) 549-1656

Catholic Charities agencies around the country have responded to HIV/AIDS through a wide variety of prevention and care services. These include:

- HIV education for at-risk individuals and groups in a variety of languages and cultures as well as for church and community audiences;

- Volunteer training for compassionate response to HIV affected individuals and families;

- Emergency services such as financial assistance for medical and domestic necessities;

- A spectrum of traditional to permanent housing;

- Medical and dental clinics;

- Foster care for HIV infected children;

- Counseling;

- Case management;

- Legal assistance;

- Transportation; and

- Support groups for clients and caregivers.

These services are provided to people of all ages, sexes, races, ethnic groups, religious and sexual orientation.

Catholic Charities HIV/AIDS programs participate in collaborative efforts within interfaith networks, Ryan White CARE Consortia and planning councils and other community efforts.

The Catholic Charities USA HIV/AIDS Committee is eager to participate in the partnership with government that the National Commission on AIDS called for in its final report.

Catholic Charities USA

Catalog of HIV/AIDS Services

Provided by
Catholic Charities Agencies

1993

Catholic Charities USA
Directory of Agencies Providing HIV/AIDS-related Services by State

	Emergency assistance	Education program	Pastoral care and social service referrals	residential care * = specific HIV prog. • = in mixed population	outpatient care clinics	Counseling	Legal/ advocacy assistance	Other
Rev. Tom Weise Catholic Social Services 400 Government Street Mobile, AL 36602 **Tele:** (205) 269-1983 **Fax:** (205) 434-1549	•	•	•	•		•	•	Socialization volunteers, volunteer and employment referrals
Catholic Charities 2164 11th Ave. South Birmingham, AL 35205 **Tele:** (205) 324-6561 **Fax:** (205) 323-0475						•		
Catholic Social Services 225 Cordova St., Building B Anchorage, AK 99501 **Tele:** (907) 277-2554 **Fax:** (907) 279-3885	•	•				•		
Administrator Catholic Community Services 419 Sixth St., Room 116 Juneau, AK 99801 **Tele:** (907) 463-3933 **Fax:** (907) 463-3237								

	Emergency assistance	Educatio program	Pastoral care and social service referrals	residential care * = specific HIV prog. • = In mixed population	outpatient care clinics	Counseling	Legal/ advocacy assistance	Other
Rev. Msgr. Edward J. Ryle Catholic Family and Community Srvs. 1825 West Northern Ave. Phoenix, AZ 85021 **Tele:** (602) 997-6105 **Fax:**			•			•		Utility assistance
Catholic Community Services 155 West Helen St. / P.O. Box 5746 Tucson, AZ 85703 **Tele:** (602) 623-0344 **Fax:** (602) 624-0381			•		•	•		Dental care
Mr. Dennis Lee Catholic Social Services 2415 North Tyler St. / P.O. Box 7239 Little Rock, AR 72217-7239 **Tele:** (501) 664-0340 **Fax:** (501) 664-9186	•	•	•					Funding to other local agencies for specific programs they operate. Referrals to state propgrams
Rev. Jim Schexnayder AIDS/ARC Services 433 Jefferson Street Oakland, CA 94607 **Tele:** (501) 451-6998 **Fax:** (501) 834-5656	•	•	•	*		•	•	Parish-based volunteer training, housing placement and case management

	Emergency assistance	Educatio program	Pastoral care and social service referrals	residential care * = specific HIV prog. • = In mixed population	outpatient care clinics	Counseling	Legal/ advocacy assistance	Other
Mr. Dale C. Meyer Catholic CharitiesAIDS-ARC Pgm 1049 Market Street, Suite 200 San Francisco, CA 94103 **Tele:** (415) 864-7400 **Fax:** (415) 588-7053	•	•	•	•	•	•	•	Not specified
Virginia Gregorieff Catholic Charities of Marin 179 Los Ranchitos San Rafael, CA 94903 **Tele:** (510) 479-1470 **Fax:** (510) 479-2667								Training volunteers
Ms. Cora Taylor Hope Houses P.O. Box 2161 Sacramento, CA 95811 **Tele:** **Fax:**				•				
Administrator Mt. St. Joseph/St. Elizabeth 100 Masonic Avenue San Francisco, CA 94118 **Tele:** (510) 567-8370 **Fax:**								

	Emergency assistance	Educatio program	Pastoral care and social service referrals	residential care ★ = specific HIV prog. • = In mixed population	outpatient care clinics	Counseling	Legal/ advocacy assistance	Other
Rev. Ralph J. Belluomini Bakersfield Catholic Charities Center 310 Baker St. Bakersfield, CA 93305 **Tele:** (805) 323-2941 **Fax:**								
Rev. Gregory Cox Catholic Charities of Los Angeles 1400 W. Ninth St. / POB 15095 Los Angeles, CA 90015-0095 **Tele:** (213) 251-3400 **Fax:** (213) 380-4603	•		•			•		
Mary Elise Robertson Catholic Social Services 1760 Fremont Blvd-Ste F-8, POB 6 Seaside, CA 93955 **Tele:** (408) 394-4656 **Fax:**	•		•			•		
Sister Kristan Schlichte, SSL Catholic Charities of Orange County 1506 Brookhollow, Suite 112 Santa Anna, CA 92705 **Tele:** (714) 662-7500 **Fax:** (714) 662-1861								Visits by Ministers to sick and deaf outreach

	Emergency assistance	Educatio program	Pastoral care and social service referrals	residential care * = specific HIV prog. • = In mixed population	outpatient care clinics	Counseling	Legal/ advocacy assistance	Other
Joseph Laharty Catholic Comunity Services 5890 Newman Court Sacramento, CA 95819 **Tele:** (916) 452-4621 **Fax:** (916) 736-0282								
Rev. Alfred LoPinto Catholic Charities 150 East Olive St. Colton, CA 92325 **Tele:** (714) 370-0800 **Fax:**	•	•	•		•			
Catholic Charities 349 Cedar St. San Diego, CA 92101-3197 **Tele:** (619) 231-2828 **Fax:** (619) 234-2272								
Bob Le Marche Catholic Charities 2625 Zanker Road Santa Clara, CA 95134-2107 **Tele:** (408) 944-0282 **Fax:** (408) 944-0275		•	•			•		Shared housing, immigration counseling, vocational rehab.

	Emergency assistance	Educatio program	Pastoral care and social service referrals	residential care * = specific HIV prog. • = in mixed population	outpatient care clinics	Counseling	Legal/ advocacy assistance	Other
Maureen E. Shaw Catholic Charities 2325 Montgomery Dr., POB 4900 Santa Rosa, CA 95402 **Tele:** (707) 528-8712 **Fax:**								
Catherine McMillan Catholic Charities 850 South Palm Canyon Dr. Palm Springs, CA 92264 **Tele:** **Fax:**	•	•	•			•		Rental assistance
Kay McMullen, SND/Alan Syslo, CSV John XXII AIDS Ministry P.O. Box 1931 Monterey, CA 93942 **Tele:** **Fax:**	•	•	•	*		•		Retreats and spiritual direction
Mr. Al Pierog Catholic Social Services 8815 99th Street Edmonton, Alberta Canada T6E 3V3 **Tele:** (403) 432-1137 **Fax:** (403) 439-2154				*		•	•	

	Emergency assistance	Educatio program	Pastoral care and social service referrals	residential care * = specific HIV prog. • = In mixed population	outpatient care clinics	Counseling	Legal/ advocacy assistance	Other
Mr. James Mauck Catholic Community Services 200 Josephine Street Denver, CO 80206 **Tele:** (308) 388-4435 **Fax:** (303) 388-6418		•		•		•		Hospice-In-home care, Bereavement support groups
Gail M. Dusing Catholic Community Services 29 West Kiowa St. Colorado Springs, CO 80903 **Tele:** (719) 636-2345 **Fax:** (719) 636-1216			•					
Rev. Martin Kapushion Catholic Social Services, Inc. 302 Jefferson St. Pueblo, CO 81004 **Tele:** (303) 544-4215 **Fax:**	•					•		
Sister Dolores Macklin, D.S.F. Catholic Charities, Inc. P.O. Box 2610 Wilmington, DE 19805-2610 **Tele:** **Fax:**	•	•	•			•		Work with CPCRA Prgm, Medical Center of Delaware and serve advisory board for HIV grants.

	Emergency assistance	Educatio program	Pastoral care and social service referrals	residential care * = specific HIV prog. • = In mixed population	outpatient care clinics	Counseling	Legal/ advocacy assistance	Other
Sister Jeanne Barnard, SSJ Associated Catholic Charities 1438 Rhode Island Ave., N.E. Washington, DC 20018 **Tele:** (202) 526-4100 **Fax:** (202) 526-1829	•	•	•	*		•		Catholic AIDS Network through parishes
Sister Editha Rojo, M.D. Catholic Community Services 9401 Biscayne Boulevard Miami Shores, FL 33138 **Tele:** (305) 754-2444 **Fax:** (305) 754-6649			•	*		•	•	30 bed residence for homeless with active AIDS
May mayfield, Regional Dir. Catholic Social Services 40 Beal Parkway Ft. Walton, FL 32548 **Tele:** (904) 244-2825 **Fax:**								
Marion M. Dickens Catholic Social Services 3128 E. 11th Street Panama City, FL 32401 **Tele:** (904) 763-0475 **Fax:** (904) 763-2969	•	•				•		

	Emergency assistance	Educatio program	Pastoral care and social service referrals	residential care * = specific HIV prog. • = In mixed population	outpatient care clinics	Counseling	Legal/ advocacy assistance	Other
Wendy Blair Catholic Social Services P.O. Box 20165 Tallahassee, FL 32316 **Tele:** (904) 222-2180 **Fax:**								
Rev. Michael P. Hogan, O.S.A. Bethesda House P.O. Box 3992 Sarasota, FL 34230 **Tele:** **Fax:**	•	•	•		•	•		Social and recreational center
Thomas Oglio Catholic Social Services 1771 North Semoran Blvd. Orlando, FL 32807 **Tele:** (407) 658-1818 **Fax:** (407) 282-2891	•		•			•		
Charles Bevacqua Catholic Charities Diocesan Center, 9995 N. Military Trail Palm Beach Gardens, FL 33410 **Tele:** (407) 775-9561 **Fax:**	•		•	•		•		

	Emergency assistance	Educatio program	Pastoral care and social service referrals	residential care * = specific HIV prog. • = In mixed population	outpatient care clinics	Counseling	Legal/ advocacy assistance	Other
Sister Mary Frances Waite, MSBT Catholic Social Services 222 East Government St. Pensacola, FL 32501 **Tele:** (904) 438-8564 **Fax:**	•		•		•	•		Medical prescriptions
Rick Carson Catholic Charities 6533 Ninth Ave. North, Suite 1-East St. Petersburg, FL 33710 **Tele:** (813) 345-3338 **Fax:** (813) 345-8902		•						Visits to clients, transporation, shopping, etc.
Robert Paul Hebert Catholic Charities P.O. Box 2116 Venice, FL 34284-2116 **Tele:** (813) 484-9543 **Fax:** (813) 484-1121	•	•	•					Food pantry
Steve Brazen Catholic Social Services, Inc. 680 West Peachtree NW Atlanta, GA 30308 **Tele:** (404) 881-6571 **Fax:** (404) 888-7816	•	•	•			•		Death and dying counseling - custodial

	Emergency assistance	Educatio program	Pastoral care and social service referrals	residential care * = specific HIV prog. • = in mixed population	outpatient care clinics	Counseling	Legal/ advocacy assistance	Other
Sister Kateri Mielnicki Office of Social Ministry 601 E. Liberty Savannah, GA 31401 **Tele:** (912) 238-2320 **Fax:** (912) 238-2335								
Juanita Iwamoto Catholic Charities, Inc. 250 South Vineyard St. Honolulu, HI 96813 **Tele:** (808) 537-6321 **Fax:** (808) 523-8773	•			•		•		Residential under development, Management, generally all agency services available
Mr. James E. Bowen Diocesan Pastoral Office P.O. Box 769 Boise, ID 83701 **Tele:** (208) 342-1311 **Fax:** (208) 342-0224		•	•					Referrals are to state services
Mr. Charles O'Reilly School of Social Work/Loyola Univ. 820 N. Michigan Avenue Chicago, IL 60611 **Tele:** **Fax:**		•						

	Emergency assistance	Educatio program	Pastoral care and social service referrals	residential care * = specific HIV prog. • = In mixed population	outpatient care clinics	Counseling	Legal/ advocacy assistance	Other
Marianne Zelewsky Catholic Charities 126 North Desplaines Street Chicago, IL 60606 **Tele:** (312) 236-5172 **Fax:** (312) 263-4290	•	•	•	•		•	•	Case Management
Mr. Michael Dalton Catholic Social Service 617 South Belt West Belleville, IL 62220-2414 **Tele:** (618) 277-9200 **Fax:**	•	•	•			•		Transportation, medication and burials, Task Force and Foster Homes
Betty J. Gilmore Catholic Social Services 2900 West Heading Ave- POB 817 Peoria, IL 61652 **Tele:** (309) 671-5700 **Fax:** (309) 671-0253			•			•		
Briston J. Fernandes Catholic Charities 921 West State St. Rockford, IL 61102 **Tele:** (815) 965-0895 **Fax:**	•	•	•			•	•	

	Emergency assistance	Educatio program	Pastoral care and social service referrals	residential care * = specific HIV prog. • = In mixed population	outpatient care clinics	Counseling	Legal/ advocacy assistance	Other
Bernard Kazyak Catholic Charities Bureau 123 N.W. Fourth St., Suite 603 Evansville, IL 47708 **Tele:** (812) 423-5456 **Fax:**								
Kathleen Donnellan Catholic Charities 315 E. Washington Blvd. Fort Wayne, IN 46802 **Tele:** (219) 422-7511 **Fax:** (219) 422-4585						•		
Executive Director Secretariat for Catholic Charities 1400 N. Meridian St - POB1410 Indianapolis, IN 46206 **Tele:** (317) 236-1500 **Fax:** (317) 236-1401								
Audra L. Cole Catholic Charities P.O. Box 2025/1671 Military Rd. Sioux City, IA 51103 **Tele:** (712) 252-2701 **Fax:**		•	•			•		Support groups for individuals and families

	Emergency assistance	Educatio program	Pastoral care and social service referrals	residential care * = specific HIV prog. • = In mixed population	outpatient care clinics	Counseling	Legal/ advocacy assistance	Other
Lawrence Breheny Catholic Council for Social Concern 818 Fifth Ave. / P.O. Box 723 Des Moines, IA 50303 **Tele:** (515) 244-3761 **Fax:** (515) 283-1982						•		
Mr. Joe Featherston Catholic Charities 1229 Mt. Loretta / PO Box 1309 Dubuque, IA 52001 **Tele:** (319) 556-2580 **Fax:** (319) 588-0557			•			•	•	
Mr. Thomas R. McHale St. Mary of the Chains College Social Work Department Dodge City, KS 67801 **Tele:** **Fax:**		•	•					Not specified
Deborah J. Snapp Catholic Social Service 332 North Oak Pratt, KS 67124 **Tele:** (316) 672-6352 **Fax:**			•					

	Emergency assistance	Educatio program	Pastoral care and social service referrals	residential care * = specific HIV prog. • = In mixed population	outpatient care clinics	Counseling	Legal/ advocacy assistance	Other
Rev. William A. Finnerty Catholic Charities 2220 Central Kansas City, KS 66102 **Tele:** (913) 621-1504 **Fax:** (913) 621-4507	●		●			●		
Rev. Msgr. Alfred J. Wasinger Catholic Charities of Salina, Inc. P.O. Box 1366/137 North Ninth St. Salina, KS 67402 **Tele:** (913) 825-0208 **Fax:**								
Patrick Rackers Catholic Social Service, Inc. 437 North Topeka St. Wichita, KS 67202 **Tele:** (316) 264-8344 **Fax:** (316) 264-4442								
Sister Joan Boberg Catholic Social Service Bureau 3629 Church St. Covington, KY 41015 **Tele:** (606) 581-8974 **Fax:**		●	●					Political/social convening and advocacy

	Emergency assistance	Educatio program	Pastoral care and social service referrals	residential care * = specific HIV prog. • = In mixed population	outpatient care clinics	Counseling	Legal/ advocacy assistance	Other
Elizabeth Greenhill, BSW Catholic Social Service Bureau 1310 Leestown Road Lexington, KY 40508 **Tele:** (606) 253-1993 **Fax:** (606) 254-6284	•		•			•		
Rev. Timothy Hogan Catholic Charities 2911 South Fourth St. Louisville, KY 40208 **Tele:** (502) 637-9786 **Fax:** (502) 637-9780								
Sister John Martin Ebrom Catholic Community Services 4400 Coliseum Blvd. Alexandria, LA 71303 **Tele:** (318) 445-2401 **Fax:**		•						Works with ecumenical groups, publicize in Catholic newspaper, network with local organizations
Paula Milner Catholic Social Services P.O. Box 2008 Lafayette, LA 70502 **Tele:** (318) 261-5654 **Fax:**			•					Serve on local HIV/AIDS board

	Emergency assistance	Educatio program	Pastoral care and social service referrals	residential care * = specific HIV prog. • = in mixed population	outpatient care clinics	Counseling	Legal/ advocacy assistance	Other
Ms. Becky Lomax Associated Catholic Charities 1000 Howard Avenue Ste 1200 New Orleans, LA 70113-1916 **Tele:** (504) 523-3755 **Fax:** (504) 523-2789	•	•	•	•	•	•	•	Transportation for PWA, Regional AIDS Interfaith Network
Mr. Gerald R. Dube Dioc Respect Life Ofc/The Chancery 510 Ocean Avenue Portland, ME 04102 **Tele:** **Fax:**		•	•	•				Housing/hospice care with other agencies
Sr. Gretchen Gilroy Catholic Charities/AIDS Ministry 49 Franklin Street Boston, MA 02110 **Tele:** (617) 482-5440 **Fax:** (617) 451-0337		•	•	•				
Ms. Margaret M. Riley St. Joseph's Hospital 220 Pawtucket Street Lowell, MA 01854 **Tele:** (508) 453-1761 **Fax:** (508) 458-9903		•				•		

	Emergency assistance	Educatio program	Pastoral care and social service referrals	residential care * = specific HIV prog. • = in mixed population	outpatient care clinics	Counseling	Legal/ advocacy assistance	Other
Rev. Peter N. Graziano Catholic Social Services 783 Slade St./POB M -So Station Fall River, MA 02724 **Tele:** (508) 674-4681 **Fax:**		•	•			•		
Catherine Loeffler Catholic Charities 15 Ripley St. Worcester, MA 01610 **Tele:** (508) 798-0191 **Fax:** (508) 797-5659								Homemaker services, homeless shelter, halfway house for substance abusers
Sister Linda O'Rourke Catholic Charities 55 Lynn Shore Drive Lynn, MA 01902 **Tele:** (617) 593-2312 **Fax:** (617) 581-3270								
Sister Ann Shea Nazareth 19 St. Joseph Street Jamaica Plain, MA 02130 **Tele:** (617) 522-4040 **Fax:** (617) 983-0460				•				operate 2 homes for girls, ages 6-12. New residence in 1992 for mothers and children with HIV/Aids

	Emergency assistance	Educatio program	Pastoral care and social service referrals	residential care * = specific HIV prog. • = In mixed population	outpatient care clinics	Counseling	Legal/ advocacy assistance	Other
CFCS - Catholic Charities 1665 M-32 West, A Building Gaylord, MI 49735 **Tele:** (517) 732-6761 **Fax:**		•	•			•		
Catholic Social Services 1152 Scribner NW Grand Rapids, MI 49504 **Tele:** (616) 456-1443 **Fax:**		•				•		
Mrs. Frances Denny Catholic Charities 1819 Gull Road St. Joseph, MI 49001 **Tele:** (616) 381-9800 **Fax:** (616) 381-2932								
Robert J. smith Catholic Charities 300 West Ottawa St. Lansing, MI 48933-1183 **Tele:** (517) 342-2462 **Fax:** (517) 342-2525								

	Emergency assistance	Educatio program	Pastoral care and social service referrals	residential care * = specific HIV prog. • = In mixed population	outpatient care clinics	Counseling	Legal/ advocacy assistance	Other
Stephen J. Lynott Catholic Social Services 347 Rock Street Marquette, MI 49855 **Tele:** (906) 228-8630 **Fax:**						•		
Ms. Judy Kalar CFCS-Catholic Charities 1000 Hastings Traverse City, MI 49684 **Tele:** (616) 947-8110 **Fax:** (616) 947-3522		•			•	•		Group Therapy for recovering substance abusers and group services to families etc of PWAs
Catholic Charities, Inc. P.O.Box 610/1200 Memorial Dr. Crookston, MN 56716 **Tele:** (218) 281-4224 **Fax:** (218) 281-3328								
Rev. Daniel Toufen Catholic Charities 1730 South Seventh Ave. St. Cloud, MN 56301 **Tele:** (612) 252-0412 **Fax:** (612) 251-3198	•		•			•		Personal care attendents in-home

	Emergency assistance	Educatio program	Pastoral care and social service referrals	residential care * = specific HIV prog. • = In mixed population	outpatient care clinics	Counseling	Legal/ advocacy assistance	Other
Catholic Social and Community Services P.O. Box 1457 / 198 Reynoir St. Biloxi, MS 39533 **Tele:** (601) 374-8316 **Fax:** (601) 435-7949		•	•					Provides office space
Rev. Elvin Sunds Catholic Charities P.O. Box 2248 / 748 N. President St. Jackson, MS 39205 **Tele:** (601) 355-8634 **Fax:** (601) 960-8455								Co-sponsored ecumenical hospice
Mr. William Donley Fr. Dunne's Newsboys Homes 853 Dunn Road Florissant, MO 63031 **Tele:** (314) 837-0513 **Fax:**				•				
Mr. Neal Colby Catholic Charities 1112 Broadway Kansas City, MO 64105-1547 **Tele:** (816) 221-4377 **Fax:** (816) 221-9116	•	•	•	*		•		Advocacy

	Emergency assistance	Educatio program	Pastoral care and social service referrals	residential care * = specific HIV prog. • = in mixed population	outpatient care clinics	Counseling	Legal/ advocacy assistance	Other
Msgr. Robert M. Krawinkel Catholic Charities 4532 Lindell Blvd. St. Louis, MO 63108 **Tele:** (314) 367-5500 **Fax:** (314) 367-6927								Archdiocesan Task Force on AIDS
Rev. Msgr. Robert Krawinkel Archdiocesan Task Force on AIDS 925 Cella Road St. Louis, MO 63124 **Tele:** **Fax:**		•	•	•	•			
Sister Lillian Baumann Fr. Tolton Catholic Outreach Center 4746 Carter Street St. Louis, MO 63115 **Tele:** (314) 367-5500 **Fax:**	•	•	•	•	•	•	•	Health Care
Sister Michele O'Brien Catholic Health Outreach Pgm 325 N. Newstead St. Louis, MO 63108 **Tele:** (314) 531-0511 **Fax:**								Provides resources to those with AIDS

	Emergency assistance	Educatio program	Pastoral care and social service referrals	residential care * = specific HIV prog. • = In mixed population	outpatient care clinics	Counseling	Legal/ advocacy assistance	Other
Rev. Joseph Walsh Catholic Social Service Bureau 327 South 70th St.-St. 200 Lincoln, NE 68510 **Tele:** (402) 474-1600 **Fax:** (402) 474-1612								
Rev. William Kelligar United Catholic Social Services 3300 N. 60th St. Omaha, NE 68104 **Tele:** (402) 554-0520 **Fax:** (402) 554-0365								
Kevin Day Catholic Community Services North P.O. Box 5415 / 275 East Fourth St. Reno, NV 89513 **Tele:** (702) 322-7073 **Fax:** (702) 322-8197	•	•						
Rev. Msgr. John P. Quinn New Hampshire Catholic Charities P.O. Box 686 / 215 Myrtle St. Manchester, NH 03104 **Tele:** (603) 669-3030 **Fax:** (603) 626-1252		•	•			•		"Buddy" and volunteer training

	Emergency assistance	Educatio program	Pastoral care and social service referrals	residential care * = specific HIV prog. • = In mixed population	outpatient care clinics	Counseling	Legal/ advocacy assistance	Other
Rev. Joseph B. Szulwach John Paul Ctr/AIDS/ARC 103 Center Street Perth Amboy, NJ 08861 **Tele:** (908) 826-6616 **Fax:**		•	•			•	•	
Ms. Frances Malley Catholic Charities 700 Sayre Avenue Phillipsberg, NJ 08865 **Tele:** **Fax:**		•	•		•	•		not specified
Mr. Frances Malley Catholic Charities F84 Park Avenue Flemington, NJ 08822 **Tele:** **Fax:**		•	•		•	•		Not specified
Director Catholic Social Services 1845 Haddon Ave. Camden, NJ 08103 **Tele:** (609) 756-7943 **Fax:** (609) 963-2655								

	Emergency assistance	Educatio program	Pastoral care and social service referrals	residential care * = specific HIV prog. • = in mixed population	outpatient care clinics	Counseling	Legal/ advocacy assistance	Other
Michael Maiello Catholic Family & Community Srvs. 10 Jackson St. Paterson, NJ 07501 **Tele:** (201) 279-7100 **Fax:**	•	•	•		•	•	•	
Francis E. Dolan Catholic Charities P.O.Box 1423/47 N. Clinton Ave. Trenton, NJ 08607-1423 **Tele:** (609) 394-5181 **Fax:** (609) 695-6978	•	•				•		Emergency shelter and food, shelter for battered women
Mr. Michael David-Wilson AIDS Center at Hope House 19-21 Belmont Avenue Dover, NJ 07802-0851 **Tele:** **Fax:**	•	•	•		•	•	•	Support groups, buddy network, recreational/social therapy, transportation, child care, Case management, Speakers Bureau
Sister Florence Ed. Kearney, DC Catholic Charities 288 Rues Lane East Brunswick, NJ 08816 **Tele:** (908) 257-6100 **Fax:**	•	•	•		•	•		Medical Services

	Emergency assistance	Educatio program	Pastoral care and social service referrals	residential care * = specific HIV prog. • = In mixed population	outpatient care clinics	Counseling	Legal/ advocacy assistance	Other
Sister Miriam Koestner Catholic Charities of Gallup, Inc. P.O. Box 1589 / Fourth and Parks St. Gallup, NM 87301 **Tele:** (505) 722-5272 **Fax:**						•		
Ms. Sue Van Alshne Catholic Charities/Comm Srvs. 27 North Main Street Albany, NY 12203 **Tele:** (518) 453-6650 **Fax:**	•	•	•	•		•	•	
Nancy Healey, R.N. Catholic Charities/Parish Hm Care 143 Schleigel Blvd. Amityville, NY 11701 **Tele:** (516) 789-5200 **Fax:** (516) 789-5214								Not specified
Thomas A. DeStefano Catholic Charities 191 Joralemon Street Brooklyn, NY 11201 **Tele:** (718) 596-5500 **Fax:** 9718) 855-5992		•	•		•	•		Bereav/burial assist., hotlines, networking w/ resource center

	Emergency assistance	Educatio program	Pastoral care and social service referrals	residential care * = specific HIV prog. • = In mixed population	outpatient care clinics	Counseling	Legal/ advocacy assistance	Other
Mr. James Trim Catholic Charities 525 Washington Street Buffalo, NY 14203 **Tele:** (716) 856-4494 **Fax:** (716) 856-2005	•		•			•	•	Substance abuse pgm and Transitional living pgm
Ms. Margaret A. Byrne Finger Lakes Office of Social Ministry 110 Exchange Street Geneva, NY 14456 **Tele:** (315) 789-2686 **Fax:**	•		•			•	•	Involvement w/ task forces, coalitions and networks
Executive Director The Astor Home for Children P.O. Box 5005 Rhinebeck, NY 12572 **Tele:** (9`4) 876-4081 **Fax:** (914) 876-2020		•		•	•			
Sharon Nyquist Maternal & Child AIDS Interv. Pgm 1150 Buffalo Road Rochester, NY 14624 **Tele:** (716) 328-3210 **Fax:** (716) 328-3149		•	•	*		•	•	

	Emergency assistance	Educatio program	Pastoral care and social service referrals	residential care * = specific HIV prog. • = In mixed population	outpatient care clinics	Counseling	Legal/ advocacy assistance	Other
Program Director Catholic Charities/Health Care Ministry 50 N. Park Avenue Rockville Centre, NY 11570 **Tele:** (516) 678-5800 **Fax:** (516) 536-7662								
Catholic Charities 1119 Elm Street Utica, NY 13501-3907 **Tele:** (315) 724-2158 **Fax:**								Residential programs for recovering alcoholics, mentally ill and MR/DD adults
Sister Una McCormack, O.P. Catholic Charities 1011 First Ave. New York, NY 10022 **Tele:** (212) 371-1000 x2525 **Fax:** (212)371-1000 x 3430		•	•	*	•	•		Center for pregnant women
Rev. Stephen H. Gratto Catholic Charities 716 Carolina St /PO Box 196 Ogdensburg, NY 13669 **Tele:** (315) 393-2660 **Fax:**	•	•	•			•		

	Emergency assistance	Educatio program	Pastoral care and social service referrals	residential care * = specific HIV prog. • = In mixed population	outpatient care clinics	Counseling	Legal/ advocacy assistance	Other
Pamela Wilson, Regional Dir. Catholic Charities 151 South Catherine St. Plattsburgh, NY 12901 **Tele:** (518) 561-0470 **Fax:**	•	•	•			•		Community Srv. Networking & Planning Devel. of Foster Care. Specialized srvs. for HIV/AIDS pregnant women, children and infants.
Ms. Kathleen Walsh Catholic Social Ministries 300 Cardinal Gibbons Drive Raleigh, NC 27606 **Tele:** (919) 821-9750 **Fax:** (919) 821-9705	•	•	•			•	•	
Sister Frnces L. Sheridan Catholic Social Services 1524 East Morehead St. Charlotte, NC 28207 **Tele:** (704) 331-1720 **Fax:** (704) 358-1208								Task force resulted in independent AIDS house
Roger E. Swinghammer Catholic Family Services 2537 South University Fargo, ND 58103 **Tele:** (701) 235-4457 **Fax:**		•						

	Emergency assistance	Educatio program	Pastoral care and social service referrals	residential care * = specific HIV prog. • = in mixed population	outpatient care clinics	Counseling	Legal/ advocacy assistance	Other
AIDS Ministry/T.V. Luckhaupt Catholic Conference of Ohio 35 E. Gay St./Suite 502 Columbus, OH 43215 **Tele:** (614) 224-7147 **Fax:** (614) 224-7150								
Madonna L. Spaeth Catholic Social Services 922 W. Riverview Avenue Dayton, OH 45407 **Tele:** (513) 223-7217 **Fax:**	•			•		•		
Ms. Josie Peroz Catholic Service League 1807 Lincoln Way East Massion, OH 44646 **Tele:** (216) 833-8516 **Fax:**	•					•		
Mr. Brian R. Corbin Catholic Charities 225 Elm Street Youngstown, OH 44503 **Tele:** (216) 744-8451 **Fax:**	•	•	•			•	•	Housing, community-based task force

	Emergency assistance	Educatio program	Pastoral care and social service referrals	residential care * = specific HIV prog. • = in mixed population	outpatient care clinics	Counseling	Legal/ advocacy assistance	Other
Raymond F. Egan Catholic Social Service 100 East Eighth St. Cincinnati, OH 45202 **Tele:** (513) 241-7745 **Fax:** (513) 241-4333	•		•		•	•		
Rev. Msgr. Gerald E. Calovini Office of Social Ministry P.O. Box 969 / 422 Washington St. Steubenville, OH 43952 **Tele:** (614) 282-6293 **Fax:**	•	•	•					
Dr. Edward Maillet Catholic Charities of the Diocese of Tulsa P.O. Box 6429 / 739 North Denver Ave. Tulsa, OK 74148 **Tele:** (918) 585-8167 **Fax:** (918) 582-2123	•			•		•		
Sister Gail Addis, I.H.M.. Associated Catholic Charities 425 NW 7th Oklahoma City, OK 73101 **Tele:** (405) 232-8514 **Fax:** (405) 232-1435	•	•	•			•		Buddy Program - Fall of 1993

	Emergency assistance	Educatio program	Pastoral care and social service referrals	residential care * = specific HIV prog. • = In mixed population	outpatient care clinics	Counseling	Legal/ advocacy assistance	Other
Dennis B. Keenan Catholic Charities, Inc. 2838 East Burnside Portland, OR 97214 **Tele:** (503) 233-8362 **Fax:** (503) 234-2545	•	•	•			•		
Mr. John R. Paul St. Vincent's Home Shelter 7201 Milnor Street Philadelphia, PA 19135 **Tele:** (215) 587-3903 **Fax:**		•	•	•		•		
Rev. Michael D. McGraw Office of Catholic Charities P.O. Box 10397 Erie, PA 16514-0397 **Tele:** (814) 824-1111 **Fax:** (814) 824-1128	•		•			•		
Rev. Msgr. Francis Kumontis Catholic Charities P.O. Box 3551 / 4800 Union Deposit Road Harrisburg, PA 17105 **Tele:** (717) 657-4804 **Fax:** (717) 657-8683			•			•		

	Emergency assistance	Educatio program	Pastoral care and social service referrals	residential care * = specific HIV prog. • = In mixed population	outpatient care clinics	Counseling	Legal/ advocacy assistance	Other
Rev. John J. Dennis, OSFS Catholic Social Services 222 North 17th St. Philadelphia, PA 19103-1299 **Tele:** (215) 587-3903 **Fax:** (215) 587-2479	●	●	●		●	●	●	4 support groups, prayer services
Rev. V. Donald Hall, Jr. Catholic Charities Agency, Inc. 115 Vannear Ave. Greensburg, PA 15601 **Tele:** (412) 467-7200 **Fax:** (412) 837-4077								
Marcel O. Charpentier Catholic Social Services 433 Elmwood Ave. Providence, RI 02907 **Tele:** (401) 467-7200 **Fax:** (401) 467-6310								
Mr. Joseph R. Pfeiffen Associated Catholic Charities 85 North Cleveland/POB 41679 Memphis, TN 38174 **Tele:** (901) 722-4777 **Fax:** (901) 722-4791			●					

	Emergency assistance	Educatio program	Pastoral care and social service referrals	residential care * = specific HIV prog. • = In mixed population	outpatient care clinics	Counseling	Legal/ advocacy assistance	Other
Sister Arlene Welding Catholic Charities 30 White Bridge Road Nashville, TN 37205 **Tele:** (615) 352-3087 **Fax:** (615) 352-8591		•	•					
Ms. Karen Spicer/Ruth Martin Parish Outreach 800 W. Loop 820 South Fort Worth, TX 76108 **Tele:** (817) 926-1231 **Fax:**	•		•	•	•	•		
Director El Carmen Center 18555-1 Leal Road San Antonio, TX 78221 **Tele:** ? **Fax:**	•	•	•		•		•	
Ms. Dolores Berkovsky Catholic Charities 2701 Burchill Road Fort Worth, TX 76105 **Tele:** (817) 921-5381 **Fax:**		•		*	•	•		Pediatric AIDS Demonstration Project-day care, respite, foster care and home-based services.

	Emergency assistance	Educatio program	Pastoral care and social service referrals	residential care ★ = specific HIV prog. • = in mixed population	outpatient care clinics	Counseling	Legal/ advocacy assistance	Other
Linda Cullen Catholic Charities 5294 Lyngate Court Burke, VA 22015 **Tele:** (703) 425-0100 **Fax:**	•							Shelter, Housing
Rev. Ward Oakshott Catholic Charities/AIDS Ministries P.O. Box 22608 Seattle, WA 98122-0608 **Tele:** (206) 328-5696/5699 **Fax:**		•	•	•		•		
Ms. Carole Sass Catholic Community Services 1918 Everett Avenue Everett, WA 98201 **Tele:** (206) 259-9188 **Fax:**								Volunteer service program for PWAs
Ms. Mary Ann Marciel St. Ann's Children's Home N. 707 Cedar Street Spokane, WA 99201 **Tele:** (509) 456-7137 **Fax:** (509) 456-7108								Residential facility for MR/DD

	Emergency assistance	Educatio program	Pastoral care and social service referrals	residential care * = specific HIV prog. • = In mixed population	outpatient care clinics	Counseling	Legal/ advocacy assistance	Other
Jack Michels Catholic Community Services 410 West 12th Street Vancouver, WA 98660 **Tele:** (206) 696-0379 **Fax:**								Not specified
Mr. James Sampson St. Charles, Inc. 151 South 84th Street Milwaukee, WI 54441 **Tele:** (414) 476-3710 **Fax:**				•				

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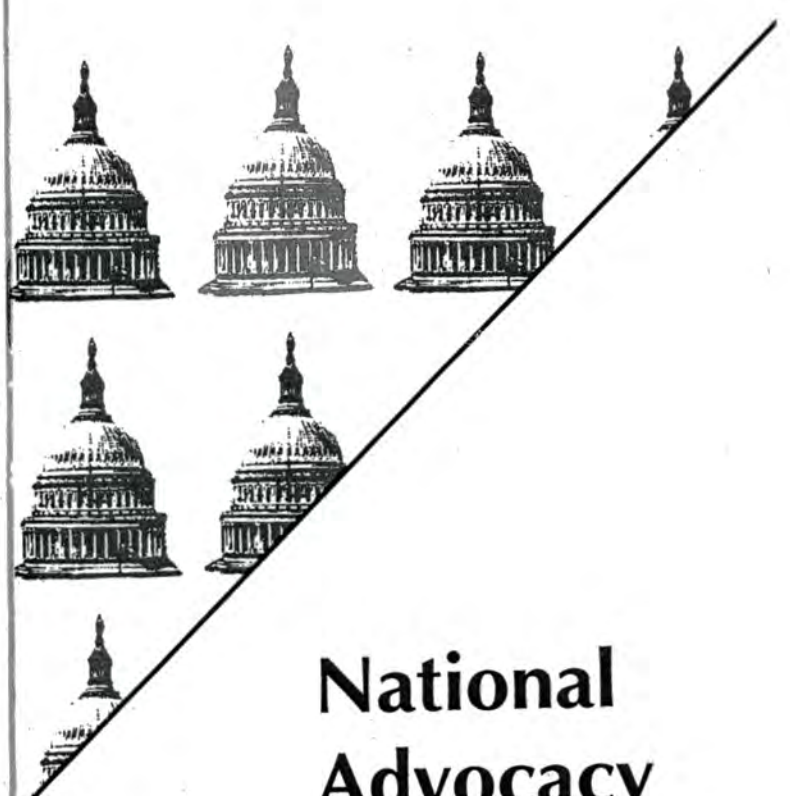
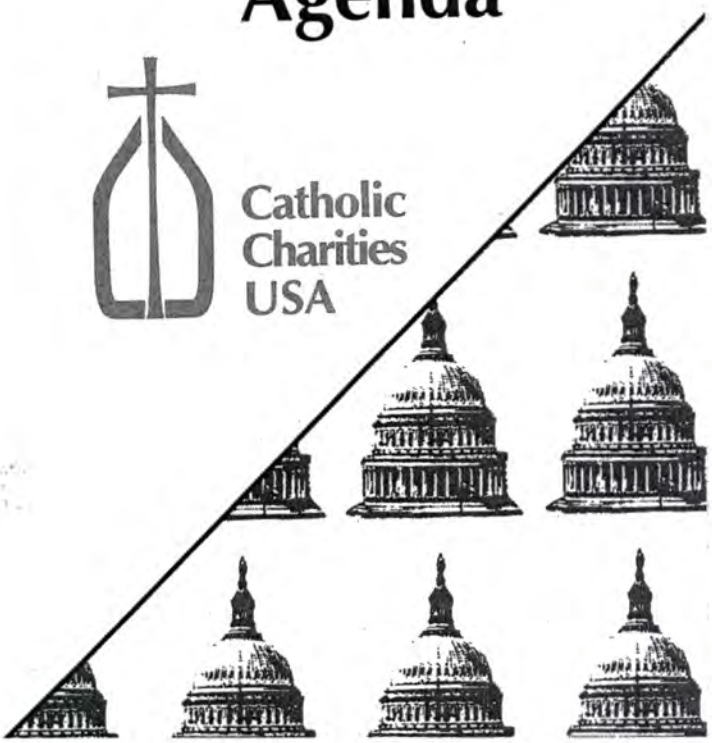
National Advocacy Agenda
Catholic Charities USA

16pgs



National Advocacy Agenda

Catholic Charities USA



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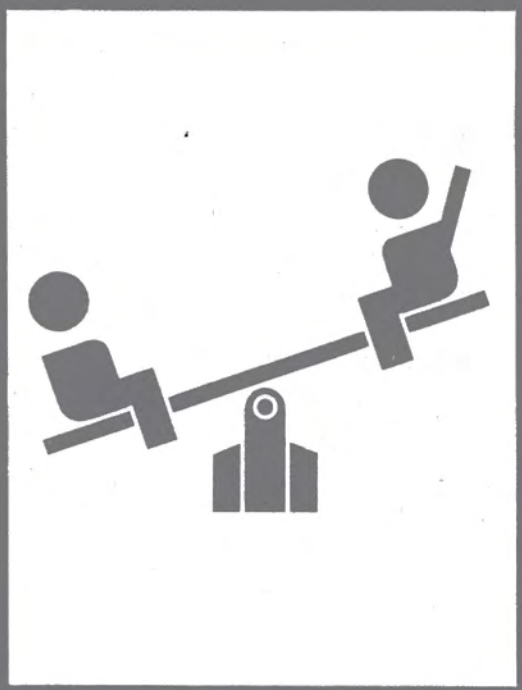
A Model Agency Policy for
Children with HIV/ARC/AIDS

19pgs

Catholic Charities USA



A Model Agency Policy

for

Children

with

HIV/ARC/AIDS

Proposed Model Policy on HIV/AIDS
for
Catholic Charities Agencies

HIV (Human Immunodeficiency Virus) is the virus that is believed to cause AIDS (Acquired Immune Deficiency Syndrome). This potentially life-threatening illness includes many phases and is increasingly known as HIV disease. The term HIV/AIDS in this document will be used to refer to the whole spectrum of HIV disease. Because of changing interventions and treatments HIV is becoming a chronic, manageable disease for an increasing number of people. HIV/AIDS is recognized in the Americans with Disabilities Act as a disability with legal protections from discrimination.

It shall be the policy of Catholic Charities USA and member agencies to address the issue of HIV disease as an employer and as a provider of services.

Catholic Charities as Employer

Hiring: Persons seeking employment shall not be discriminated against on the basis of HIV/AIDS.

Continuing Employment: Employment shall not be terminated on the basis of HIV/AIDS unless a person is unable to continue his/her duties or is a hazard to self or others due to neurological difficulties.

Benefits: If a person is unable to continue employment, benefits shall be in accord with agency policy pertaining to employees with any other disability or illness.

Job Modification: As necessary, medical documentation will be requested to support requests for job restructuring or reassignment.

Insurance coverage: Employee insurance plans should cover treatment and care of HIV/AIDS in the same way as provided for other illness or disabilities.

Psychosocial Support: Confidential counseling and support services should be available to the individual and his/her family during and after employment through agency and community-based resources.

*Confidentiality: T*he identity of a person with HIV/AIDS is confidential and every precaution shall be taken to protect that confidentiality. In addition to the ethical aspects, this can also be a legal issue since in some states law protects disclosure of HIV status unless authorized for specifically designated persons.

Board Members and Volunteers: No discrimination based on HIV/AIDS shall be used in the selection or continuation of Catholic Charities board members or volunteers.

Catholic Charities as Provider of Services

Admissions Policies: There shall be no discrimination in accepting clients with HIV/AIDS into any Catholic Charities program. Admission criteria governing intake policy are to be followed. Identification of persons "at risk" will be accomplished by means of the social history interview. Admission of residents who have a history of inappropriate sexual activity, drug use or unusual physical aggression including biting or harming others will be accepted or rejected based on a program's ability to meet the client's needs without undue hazard to others.

Screening: There will be no routine or mass HIV antibody testing of incoming residents or of residents already in placement. Testing of high risk infants and children may be done based on physician recommendation. Testing for adults will be voluntary and will be done only with informed consent. Pre- and post-test counseling should always be provided. Testing policies must always reflect up-to-date medical, legal and ethical principles.

Health Care: A client deemed at risk shall be monitored for HIV/AIDS symptoms and encouraged to be tested for early treatment. Health care will be provided within a residential program as long as the resident can function within a normal or modified daily schedule. If 24 hour bed care becomes necessary and medically prescribed treatment is not available within the program, regular discharge procedures will be initiated in view of a more appropriate health care provider. Every effort will be made to assist the resident and family in making the most appropriate decisions regarding care of the person.

Confidentiality: The identity of a client with HIV/AIDS is confidential and every precaution will be taken to maintain that confidentiality. Appropriate information will be shared with employees who, because of their immediate responsibility for clients, must have knowledge of the diagnosis. This determination should be made by the primary care provider or team. Universal precautions are the standard norms for protecting health care workers. This precludes inappropriate and unauthorized disclosure of HIV status.

Collaboration: Catholic Charities agencies should be coordinated with community services to ensure that people living with HIV/AIDS can easily access all available services. Catholic Charities agencies should work with others to identify unmet needs in HIV/AIDS services.

Education: Education is the most important weapon in combating HIV/AIDS. An educational program should be established for employees and residents. This program should be conducted on a regular basis and should include:

1. Up-to-date information pertaining to the basic medical and psychosocial dimensions of HIV/AIDS;
2. Epidemiology, transmission, prevention, universal precautions and testing;
3. Current agency policy and procedures;
4. Local community resources;

5. Sensitivity and varied responses appropriate for people of color, homeless, undocumented, migrants, disabled, deaf and hearing impaired, prisoners, women and children, homosexuals, bisexuals and lesbians, substance and sex addicted, and those living in rural areas.

Appropriate HIV/AIDS prevention information should also be provided clients.

Spiritual Support/Pastoral Care: Agencies should provide or work in collaboration with those who provide a full range of spiritual resources for its diverse HIV/AIDS affected clients, which include the infected, their families and caregivers.

Public Policy: Catholic Charities agencies should support legislation that protects the personal dignity and civil rights of people affected by HIV/AIDS and speak publicly against legislation or other policy of government, business or church institutions that threatens those same rights. The social teachings of the church should inform this advocacy effort. Agencies should also promote adequate funding for HIV/AIDS services, for community-based programs, and for universal health care access.

Catholic Charities has the unique opportunity to convene HIV/AIDS service providers for collaboration and support.

Evaluation of This Policy

Since HIV disease is continually changing in its medical, legal and ethical implications this policy should be periodically updated and re-evaluated so that it may appropriately respond to on-going needs.

This model policy is largely adapted from *"The Client and Program Specific Policies"*, Associated Catholic Charities of New Orleans, with additional aspects from *"A Suggested Outline for a Diocesan AIDS Policy"* proposed by the Western States Catholic AIDS Coalition.

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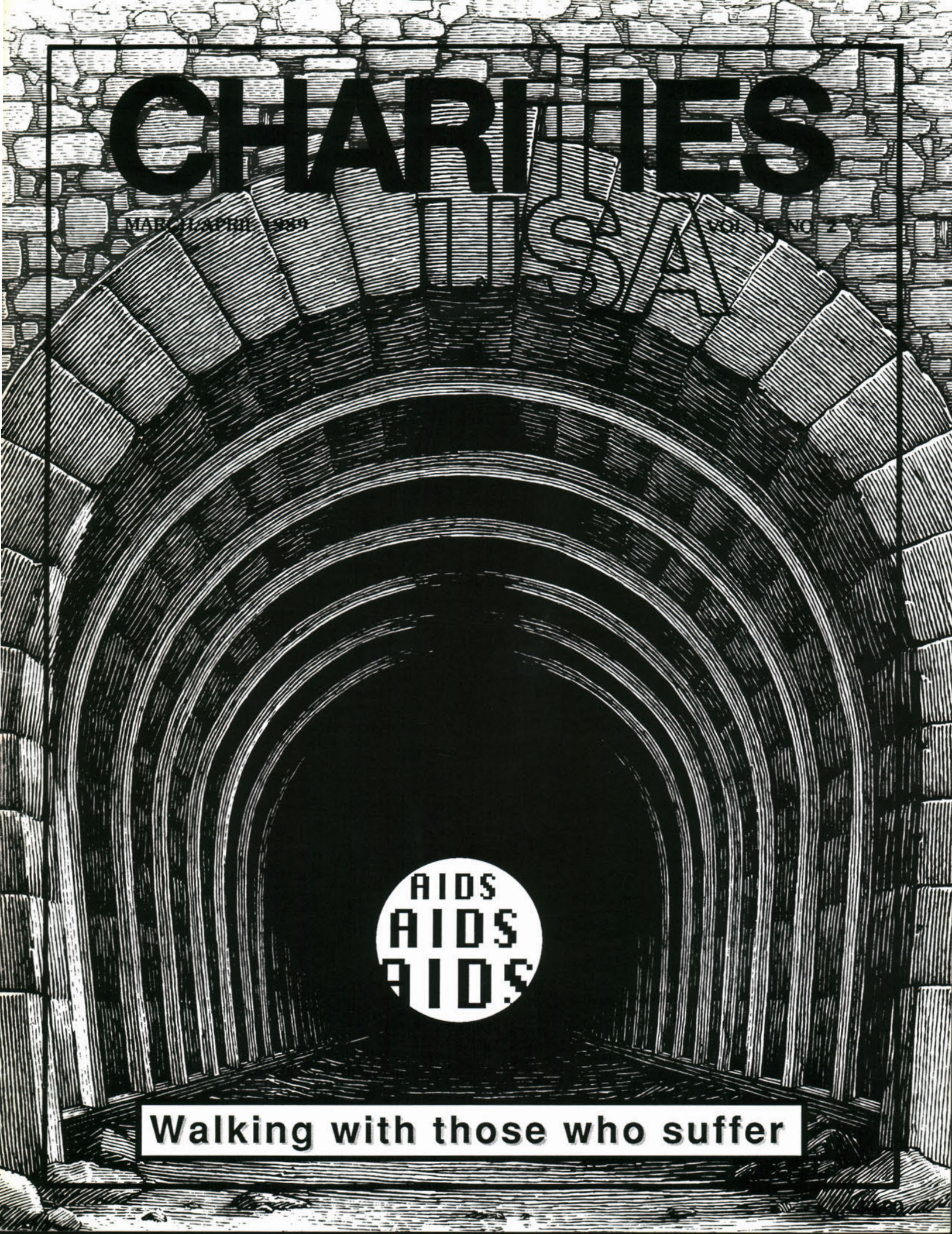
CHARITIES USA

MARCH/APRIL 1989 VOL. 15, NO. 2



Walking with those who suffer

LOS ANGELES COUNTY
COMMISSION ON HIV AND AIDS

600 S. Commonwealth Avenue, 6th Floor ○ Los Angeles, CA 90005 ○ (213) 351-8088 ○ FAX: (213) 738-0825

October 7, 1993

Kristine Gebbie
National AIDS Policy Coordinator
Hubert H. Humphrey Blvd., Room 728-H
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Ms. Gebbie:

On behalf of the Los Angeles County Commission on HIV and AIDS, I would like to extend an invitation to you to come to Los Angeles to participate in an open forum to allow the HIV-infected and affected communities to provide you with input.

As you know, Los Angeles County ranks as having the second highest number of HIV cases in the country. I think you will find that Los Angeles' HIV treatment capacity and resources have changed dramatically over the past three years with the infusion of CARE Act funds. We would like to have you witness this growth and let you know of our continued needs.

We are working actively with two other key groups in Los Angeles, the HIV Health Services Planning Council and the AIDS Regional Board, on these issues and a number of others.

I look forward to hearing from you. You can reach me at (310) 603-8166 to discuss your visit.

Very truly yours,

Wilbert C. Jordan, M.D., Chairperson
Commission on HIV and AIDS

par

6th National HIV/AIDS Update Conference
October 19-23, 1993

Plenary & Workshop Schedules

Plenary Speakers

Wednesday, Oct. 20.1993, 9:15-10:30 a.m. (Opening Plenary)

"Scientific Update: Anti-retroviral Update."
Paul A. Volberding, MD
Professor of Medicine, UCSF
Director, AIDS Program, San Francisco General Hospital

"Learning from the Past, Moving Toward the Future."
Jeanne White
President and Founder, Ryan White Foundation
Indianapolis, IN

"Worldwide HIV Vaccine: Reality or Illusion?"
Donald P. Francis, MD, DSc
HIV/AIDS Consultant
Hillsborough, CA

Thursday, Oct. 21, 1993, 9:00-10:30 a.m.

"Social and Political Strategies for the HIV Epidemic"
Ana O. Dumois, PhD, DSW
Executive Director
Community Family Planning Council
New York, NY

"Healthcare Reform and the HIV Epidemic."
Mark D. Smith, MD, MBA
Executive Vice-President
Kaiser Family Foundation
Menlo Park, CA

"Evaluating Our Past Experiences to Plan for the Future."
Vincent Mor, PhD
Director, Center for Gerontological & Health Care Research
Professor, Medical Sciences
Brown University
Providence, RI

"Substance Abuse and the HIV Epidemic:
Applying Past Experiences for the Control of the HIV Epidemic."
Don DesJarlais, PhD
Research Director, Beth Israel Medical Center
Chemical Dependency Institute
New York, NY

Friday, Oct. 22, 1993, 9:00-10:30 a.m.

"The Future for Nursing in the HIV Epidemic."
Marilyn Chow, DNSc, RN, FAAN
Former President & CEO, National League for Health Care
New York, NY

"The Future in HIV Research: Will We Learn from the Past?"
Sten Vermund, MD, PhD
Chief, Vaccine and Epidemiology, Division of AIDS
NIAID, National Institutes of Health
Bethesda, MD

"Issues for the Gay Community in Treatment and Research."
Derek Hodel
Director, Treatment and Research
AIDS Action Council
Washington, DC

Friday, Oct. 22, 1993, 5:15-5:45 (Closing Ceremony)

Keynote Address:
"HIV Policy: Learning from the Past, Focusing on the Future."
Kristine Gebbie, MN, RN, FAAN
National AIDS Policy Coordinator
Washington, DC

Hi-Vibrations, Musical Presentation

Mary Pittman, Dr. P.H., Closing Remarks
Conference Co-Chair
The Hospital Research & Educational Trust
The American Hospital Association
Chicago, IL

SF AIDS FOUNDATION

SAN FRANCISCO AIDS FOUNDATION P.O. BOX 426182, SAN FRANCISCO, CALIFORNIA 94142-6182

MEETING AGENDA

Kristine Gebbie, National AIDS Policy Coordinator
Friday, October 22nd, 8:30-9:40 a.m.

Facilitators: Paul Di Donato and Patricia Dunn

This agenda was set by those in attendance at the planning meeting October 21st. We must ask that only designated spokespeople talk and that time limits be respected. There will also be an opportunity for people to ask questions and make comments at the general meeting beginning at 10:30. Speakers should introduce themselves.

1.	Ryan White CARE Act -Appropriations -Reauthorization **-Jerry Windley and Mike Shriver**	**8:30-8:35**
2.	Drug Treatment Funding **-Gene Copello**	**8:35-8:36**
3.	Health Care Reform **-Paul Di Donato**	**8:36-8:45**
4.	Prevention Reform **-Jim Kahn, Kerrington Osborne, Mike Shriver, Tom Coates, Sharen Trammel, Pat Franks**	**8:45-8:55**
5.	Needle Exchange **-Jim Kahn and Geoffrey Sackett**	**8:55-9:00**
6.	Housing **-Bob Nelson**	**9:00-9:05**
7.	Immigrants **-Tomás Fabregás**	**9:05-9:10**
8.	FDA Regs/Women and Clinical Trials **-Rebecca Dennison**	**9:10-9:12**
9.	Standby Guardianship **-Rebecca Dennison**	**9:12-9:14**
10.	Poppers **-Hank Wilson**	**9:14-9:16**
11.	Research and Treatment Development **-Anne Donnelly and David Lewis**	**9:16-9:21**
12.	Other e.g., Concerns Related to Specific Populations	**9:21-9:40**

25 VAN NESS AVENUE, SUITE 660 / 1170 MARKET STREET, 5TH FLOOR
SAN FRANCISCO, CALIFORNIA 94102
(415) 864-5855

Please Sign In

Name	Organization	mailing address
Bob Nelson	Catholic Charities Nat'l HIV Housing Coal.	1049 Market #200 SF 94103
Joe Fier	SF AIDS Foundation	PO Box 426182 SF Ca 94142-6182
DAVE FORD	SF AIDS Foundation	PO Box 426182 SF, CA 94142-6182
LES PAPPAS	S.F. AIDS FOUNDATION	PO Box 426182 SFCA 94142-6182
HANK WILSON	COMMITTEE TO MONITOR POPPERS/ACT-UP GOLDENGATE	55 MASON ST SFCA 94102
Rebecca Denison	WORLD	POB 11535 Oakland CA 94611
Les Hanson	Am Indian AIDS Institute	333 Valencia #400 SF, CA 94103
✓ Kerrington Osborne, Esq.	National Task Force on AIDS Prevention	631 O'Farrell St SF, CA 94109
Willi McFarland	Center for AIDS Prevention Studies, UCSF	74 New Montgomery SF, CA 9405
Jo Messore	OFFICE NAT AIDS POLICY COOR	200 IND AVE SW DC 20201
Kris Belberg	Off. of Nat. AIDS Policy Coor.	200 Independence DC. 20201
Tom Coates	Center for AIDS Prevention Studies, UCSF	74 New Montgomery #600 SF CA 94105

Steve Morin Rep. Nancy Pelosi 450 Golden Gate Ave. SF, CA 94102

KATHERINE HAYNES SANSTAD, Director TIG Core
Center for AIDS Prevention Studies, UCSF
74 New Montgomery St, ste 600, SF, CA 94105

CYNTHIA GOMEZ, Ph.D.
INVESTIGATOR, CENTER FOR AIDS PREVENTION STUDIES,
UCSF
74 NEW MONTGOMERY SUITE 600
SAN FRANCISCO, CA 94105

Steve Burns Project Open Hand 2720 17th St. San Francisco 94110
Michelle Aldrich - AIDS Prevention Action Network
2755 Franklin #7 SF CA 94123

Sharon Trammell
Black Coalition on AIDS
1042 Divisadero
San Francisco, CA 94115

Jim Kahn
Institute for Health Policy Studies - SFGH, Box 0856
Univ. of Calif, San Francisco CA
94143

PAT FRANKS — Institute for Health Policy Studies / Center for AIDS Prevention Studies, UCSF — 1388 Sutter St 11th floor SF, CA 94109

David D. Lewis — Project Inform
1965 Market St. #220
SF, CA 94103
415 558-8669

Jerry Windley — office of Supervisor Angela Alioto
Room 235 - City Hall
SF. 94102
(415) 554-7788
(415) 554-5163 (Fax)

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NOV - 3 1993

10/28/93

Mrs. Gebbie;

Thank you for meeting with us and sharing our concerns. I am hopeful for the future even if I am not to be part of it. Please continue to keep in touch with those of us who are living with AIDS, afterall, we are the experts and are capable of identifying our needs. I will be following your efforts and wish you success!

Mary Drake
PWA

AIDS
PROJECT
LOS ANGELES

Mary Drake
139 W. 64th Pl. #2
Inglewood, Ca. 90302

019697

02:06 10/31/93

Kristine Gebbie
National Aids Policy Coor.
Executive Office of the President
Washington, DC 20500

10/27/93

NOV - 3 1993

Ms. Gebbie,

Thank you for attending the luncheon today at the APLA office. I am very encouraged to hear your plans and the direction you are taking in the fight against AIDS.

I would like to see you more "in the spotlight" - promoting your agenda as too many people are still unaware of the reality that surrounds them.

Again - thank you for taking the time to meet with us, and please don't lose your enthusiasm for this vital post you have taken on.

Sincerely, Peter Swenke

— PETER SWENKE

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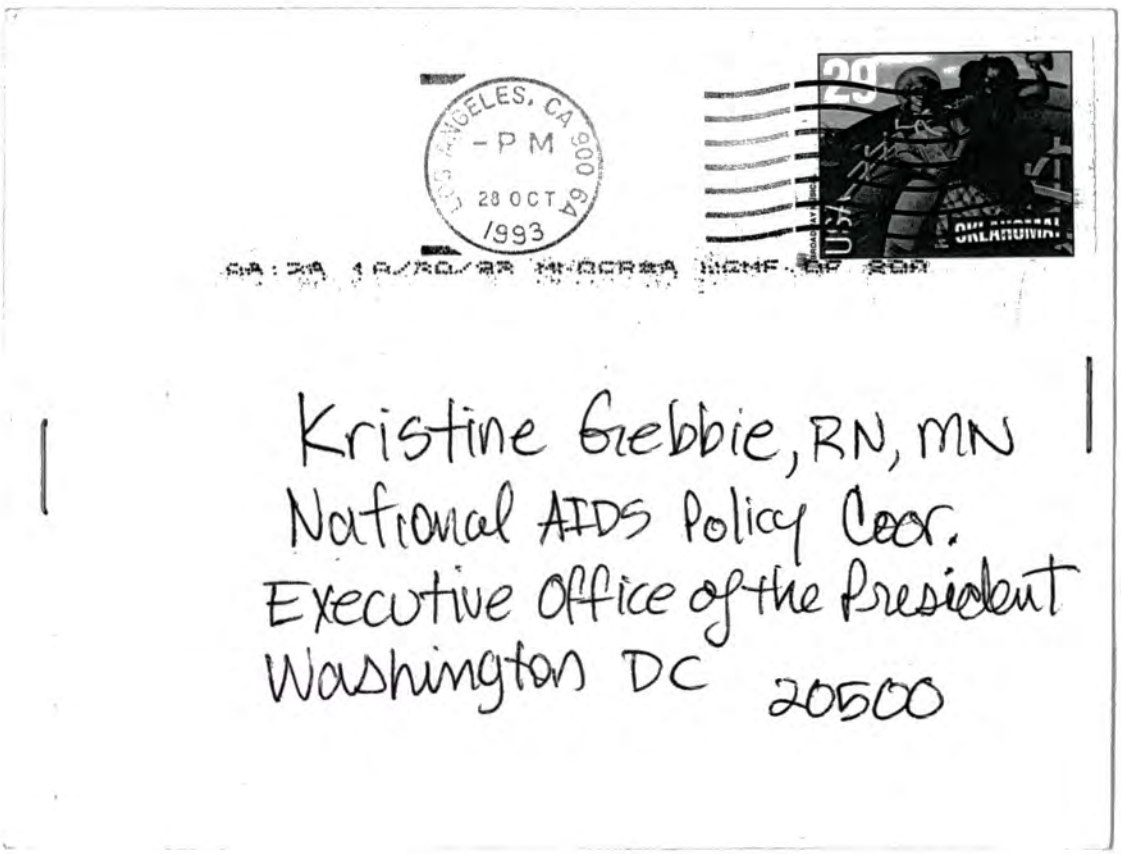

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PETER SWENKE
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