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FOR IMMEDIATE RELEASE
April 20, 1994

Contact: Gregory Adams
202/544-1076 ext. 326 (voice)
202/544-9397 (fax)
202/773-2372 (pager)

NATIONAL MINORITY AIDS COUNCIL RESPONDS TO CONTROVERSY SURROUNDING NATIONAL AIDS POLICY OFFICE

NATIONAL MINORITY AIDS COUNCIL

300 Eye Street, NE
Suite 400
Washington, DC
20002-4389
tel 202-544-1076
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Washington, DC -- Paul Akio Kawata, the executive director of the National Minority AIDS Council, today responded to the controversy surrounding the Office of National AIDS Policy's release last week of a draft document entitled the *National AIDS Action Agenda*. The following quotes may be attributed to Mr. Kawata:

(On the release of the National AIDS Action Agenda)
"Releasing this document in draft form was an unfortunate misstep. The process to solicit community input is critical. However, fourteen years into the epidemic we hoped for more substance. We look forward to working with Kristine Gebbie as she puts together this national plan to ensure inclusion of critical isues for people of color."

(On Kristine Gebbie)
"She's in a very difficult position. We've waited so long for leadership that I'm not sure any individual could meet all of the expectations of the diverse communities affected by HIV/AIDS."

--030--

The National Minority AIDS Council was formed in 1987 to develop leadership within communities of color to address issues of HIV infection. Our members are community-based organizations that deal with AIDS on the frontlines -- in hospitals and clinics, shelters and schools, storefronts and streets. Thousands of men and women of color rely on such organizations for outreach, care, education, housing and support services. NMAC's goals are to lend visibility, leadership, comprehensive technical support and a powerful national voice to these front line AIDS workers.

March 21, 1994

To: NAPO Staff

From: Matthew Murguia

Re: 1989 National Minority HIV Conference

As discussed during the last all staff meeting, attached is an overview of the national minority HIV conference. We anticipate that the next planning meeting for the conference will occur in late April. At that time, we will begin the process of identifying workshops/speakers for the conference based on the tracks, outcomes and target audiences. If there are particular workshops or speakers who you believe ought to be considered by the track planning committees, please forward that information to either me or Hazel at your earliest convenience.

As discussed during the staff meeting, attendance at the conference will be limited to approximately 750 community-based individuals. Thus, not all who may want to attend the conference will be able to register. Please do not share the conference information with members of the community until after plans have been finalized regarding registration procedures.

If you would like a list of the community co-chairs or of the community members of the executive planning committee, please let either me or Hazel know. Federal agencies are in the process of identifying who will represent them in the planning process. CDC, NIH and HRSA are required to detail someone to NAPO to assist in this effort.

Thank you for your assistance.

BREAKING BARRIERS, BUILDING BRIDGES

1994 NATIONAL MINORITY HIV/AIDS CONGRESS

WORKING FORMAT

Coordinating Entities:

National AIDS Policy Office (NAPO)
Deputy Assistant Secretary for Health Communications (DASH-C)

Participating Public Health Service Agencies/OASH Staff Offices:

Agency for Health Care Policy and Research (AHCPR)
Centers for Disease Control and Prevention (CDC)
Food and Drug Administration (FDA)
Health Resources and Services Administration (HRSA)
Indian Health Service (IHS)
National Institutes of Health (NIH)
Substance Abuse and Mental Health Services Administration (SAMHSA)
Office of the Surgeon General (OSG)
Office of Minority Health (OMH/OASH)

Conference Logistics

A national firm with strong expertise in conference management has been identified to assist in organizing this conference. This contractor has extensive expertise in working with racial and ethnic minority populations and in HIV-related issues. The contractor will be required to furnish the personnel, facilities, materials, supplies, and equipment necessary to assist in the planning, scheduling, managing, and implementing of a three and one-half day national conference on HIV in racial and ethnic populations. The conference will be held in September 1994. The conference is expected to have approximately 750 non-federal attendees.

The contractor will concern itself with logistical/financial issues only and will not be involved in the programmatic content of the conference.

Conference Title:

"Breaking Barriers, Building Bridges: The First National Congress on the State of HIV/AIDS in Racial and Ethnic Minority Communities." The 1994 National Minority HIV/AIDS Congress.

Conference Purpose:

Convene the first national congress on the state of the HIV/AIDS epidemic in racial and ethnic communities with a special emphasis on policies in the areas of prevention, services and research.

Conference Size:

It is anticipated that 750 community-based individuals will attend this conference. Federal attendance is estimated to be between 100 and 150 individuals.

Conference Location:

Washington, D.C.

Conference Date:

September 15 - 18, 1994 is the anticipated conference date.

Conference Methods:

- One day race/ethnic specific institutes designed to provide a forum for the development of broad-based population and community "action plans" to address internal and external barriers, including those faced by non-minorities working with minority populations;
- Workshop/plenary sessions highlighting successful federal and private sector minority-focused efforts;
- Identification of barriers and potential solutions to overcome them; and
- Development of "action" plans (a set of action steps an individual could advocate for upon return to their community).

Conference Outcomes:

- Energize community leadership;
- Sharing information/updates highlighting successful minority-run and minority-focused models;
- Action plans developed by participants;
- Development of a publication/report summarizing results of the conference (for distribution to community, policymakers and others); and
- Provide added national focus to the nature and impact of the HIV epidemic in racial and ethnic minority populations.

Proposed Target Audience

Participants for this conference are expected to number 750 and to include the following types of representatives:

- Existing and emerging racial/ethnic minority players in HIV prevention, services and research, with a particular emphasis on "front-line" individuals, including those with HIV
- HIV infected individuals
- Prevention workers
- Social services providers
- Health care workers
- Substance abuse workers
- HIV researchers
- HIV policymakers/advocates
- Federal, state and local government HIV program managers, policy analysts and program developers
- special emphasis will be placed on individuals under 25 years old

CONFERENCE FORMAT

Institutes:

- Five separate, but related, one day race/ethnic specific (including one for non-minorities) institutes will be held at the beginning of the conference. These institutes will be designed to provide a forum for the development of broad-

based population and community "action plans" to address internal and external barriers, including those faced by non-minorities working with minority populations. These action plans will be summarized and distributed during the conference for use by individual participants upon returning to their community. The institutes will allow individuals to address issues specific to their race/ethnicity as a means of identifying barriers and identifying steps to overcome those barriers.

Tracks:

- The conference will have three tracks:

  1) HIV Prevention
  2) HIV Services
  3) HIV Research

Each track will focus on programmatic and policy issues important in addressing HIV in racial/ethnic populations. Each track will be inclusive of issues, e.g., the Services Track may include workshops on Ryan White planning councils, medical care in correctional facilities, housing issues, orphans, etc.

Workshops:

- The conference will consist of approximately 80 workshops divided among three tracks:

  - Prevention (+/- 35 workshops)
  - Services (+/- 30 workshops)
  - Research (+/- 15 workshops)

- Using successful minority-focused models or minority-focused topics, each workshop will last approximately 1 1/2 hours and will be structured as follows:

  - Definition of issue or need/identification of barriers;
  - Program design/structure used to meet need/overcome barrier;
  - Rationale for program design; and
  - How to implement/replicate (action steps).

Plenary Sessions:

- Five plenary sessions (including opening and closing) are tentatively planned to occur during the conference. An optional plenary on health care reform may be presented.

NOTE: THE SCHEDULE BELOW MAY BE CHANGED DEPENDING ON THE DAY OF THE WEEK THE CONFERENCE BEGINS

Pre-Conference	Facilitator Training Registration
Day 1	Registration Institutes (9 a.m. - 3:00 p.m.) Opening **Plenary**/HIV in Minority Populations Overview (4:00 - 6:00 p.m.) Cultural Celebration
Day 2	**Plenary** (Prevention) Workshops I Luncheon **Plenary** (Services) Workshops II Affinity Groups Private Evening Event
Day 3	Workshops III Agency Meetings Luncheon **Plenary** (Research) Workshops IV Private Evening Event
Day 4	Closing **Plenary** Agency Report Outs Cultural Celebration

Agency Meetings:

Each of the PHS Agencies, as well as several other Federal departments, will be asked to coordinate an "agency meeting," during the conference. Specific time and space has been allocated to allow each agency to meet with conference participants. Each agency, meeting in a separate room, will be able to present an overview of their agency, then engage in open-ended discussion about the agency's mission, role, and programs. Participants will have the opportunity to ask questions, share concerns, and provide input into agency activities. While it will be discouraged, participants will be able to move from one agency's meeting to another.

General:

- Time and space will be allocated for approximately 20 affinity group meetings as part of the daily schedule of activities. Notetakers will be available to assist in developing summary reports. Time has been allocated for a summary of each major Affinity Group meeting to be briefly presented during the closing plenary session. In addition, a copy of each affinity group's report will be included in a conference report.

- Exhibitors will be invited to participate for a fee, with community-based organizations being charged less than for-profit entities.

- A media resource room will be available for display of materials, videos, etc.

- Cultural presentations highlighting each of the four racial/ethnic minority groups will be included as part of the official program.

- Evening entertainment/receptions may occur on at least two, possibly three evenings. These events would be financed by private sector fund-raising or as an optional addition to the registration fee.

- The luncheon plenary session on Day 3 will be arranged so that participants with a common interest (e.g., prevention, services, research, or topical interest (e.g., homeless, Ryan White) may sit with each other during lunch.

- Facilitator training would occur on at least two occasions prior to or during the conference.

CONFERENCE PLANNING STRUCTURE

- The National AIDS Policy Office and the Deputy Assistant Secretary for Health Communications will coordinate all aspects of organizing the conference, including identifying and securing a logistics contractor.

- CDC, HRSA, and NIH will serve as lead agencies in developing workshops and plenary sessions to be conducted under each of the Tracks: CDC will coordinate planning for the Prevention Track; HRSA will coordinate planning for the Services Track; and NIH will coordinate planning for the Research Track. The Tracks will focus on programmatic and policy issues related to HIV in racial/ethnic minority populations; each track will address overlapping issues.

- CDC, HRSA, and NIH will each detail to NAPO one individual to serve as the coordinator for their respective Track. They will be responsible for overseeing the development of all aspects of the Track (e.g., development of recommended workshops, speakers, contact information, etc.). Each Track Coordinator will utilize members of the current planning committee to assist in the development of their track, and may add other Federal and non-federal individuals, if necessary. Each track will be co-chaired by a federal and non-federal member of the planning committee. As has been done with previous planning committees, each Track planning committee should have a membership which is representative in terms of race, ethnicity, HIV status, gender, sexual orientation, and urban/rural background.

- SAMHSA will assist HRSA in developing the Services Track. FDA will assist NIH in developing the Research Track. AHCPR, IHS, OMH and the OSG will assist each of the lead agencies in developing their respective tracks. Each agency should utilize the experience and knowledge of the other agencies in planning their Tracks.

The following structure is being used for planning purposes:

NAPO/DASH-C

CDC*	HRSA*	NIH*
Prevention Track	Services Track	Research Track
Planning Group	Planning Group	Planning Group

* Other PHS agencies/offices, including AHCPR, IHS, SAMHSA, FDA, OMH and OSG will assist with planning efforts.

- Each Track coordinator is responsible for developing workshops for presentation, including the identification of topics, presenters and relevant contact information.

LEAD PHS AGENCY/OFFICE RESPONSIBILITIES:

NAPO and DASH-C Responsibilities:

- Day-to-day coordination of all contract related activities, including development of a scope of work for the contract and assignment of appropriate staff to serve as project officer for the contract;

- NAPO and DASH-C will coordinate all planning efforts of the agencies. Information regarding the available number of workshops, time slots, plenary sessions, etc, will be provided to CDC, HRSA and NIH. NAPO and DASH-C will be responsible for ensuring that planning meeting occur on a regular basis and that community input is solicited throughout the process;

- In consultation with community representatives and federal agencies, identify all opening and closing plenary sessions speakers;

- In consultation with the PHS agencies, provide final approval of workshop and plenary topics and speakers; and

- Assist planning committee members in developing the basic framework for workshops/plenaries; assist in the development of framework for racial/ethnic institutes.

Agency Responsibilities

- Full participation and commitment in planning the content aspects of the conference;

- PHS agencies will provide financial support for the conference;

- Identification of professional staff with commitment authority and background in HIV/AIDS issues;

- In consultation with community representatives, identification and recommendation of workshops and plenary topics, speakers and presenters, including relevant contact information;

- In consultation with community representatives, provide the contractor with names and addresses of organizations and individuals to be used in developing a comprehensive mailing list to receive registration information;

- Developing short descriptions of workshops and respective plenary sessions for use in conference-related materials;

- Assisting in the development of a conference participant package which will include resource information, data, summary of agency programs, etc.; and

- CDC, HRSA and NIH will each be responsible for identifying a spokesperson for their agency who provide summary of issues/concerns raised during the conference which their agency addresses and present them at the closing session. (Other PHS agencies may be requested to present as well.)

Planning Member Responsibilities

- Full participation and commitment in planning the content and/or logistics aspects of the conference;

- Assist in the identification and recommendation of workshops and plenary topics, speakers and presenters, including relevant contact information;

- Provide names and addresses of organizations and individuals to be used in developing mailing lists to receive registration information;

- Assist in the development of short descriptions of workshops and respective plenary sessions for use in conference-related materials;

- Assisting in the identification of information for inclusion in a conference participant package which will include resource information, data, summary of agency programs, etc.; and

- Volunteering to serve as a member of at least one content or logistics related track. Community participants may not volunteer only for a logistics track.

- Agree to fully participate in planning committee meetings (or conference calls), attending them on a regular basis.

San Diego County Ecumenical Conference
AIDS CHAPLAINCY PROGRAM

Rev. Glenn Allison
Chair

June 18, 1993

Vince Rodriguez
Conference Manager
NATIONAL MINORITY AIDS COUNCIL
300 Eye Street, NE, Suite 400
Washington, DC. 20002-4389

Dear Vince:

I would like to thank you and the NATIONAL MINORITY AIDS COUNCIL for the scholarship that made it possible for my participation at the April Policy Conference, **"Our Place at the Table."**

I left Washington, DC, feeling empowered by the Honorable Donna Shalala, Secretary of the Department of Health and Human Services; Representative Nydia Velazquez; Representative Maxine Waters; and Cecilia Munoz, Senior Immigration Policy Analyst of the NATIONAL COUNCIL OF LA RAZA.

Enclosed is the survey of "**OUR PLACE AT THE TABLE.**" Please also note the cover letter addressed to the **AIDS CHAPLAINCY Search Committee** which I have enclosed as an example of work inspired by the conference.

Your organization has accomplished impressive work in empowering the HIV/AIDS minority community. As the Chairperson of the HIV-CARE Coalition, Outreach/Public Relations Committee, I am proud to be a part of the network of the NATIONAL MINORITY AIDS COUNCIL.

Sincerely,

Victor Montalvo Sanchez
Executive Board, AIDS Chaplaincy Program
Chairman/HIV-CARE Coalition, Outreach and Public Relations Committee

P.O. Box 34607, San Diego, California 92103 □ (619) 294-7753

February 20, 1994

RECEIVED

FEB 28 1994

Binnie Callender
Office of AIDS Coordination
P.O. Box 85524
San Diego, California 92138-5524

Dear Ms: Callender

As an active Hispanic/Latino leader living with AIDS and as an advocate for issues, barriers, and problems in meeting the needs within the Hispanic Community I would like to formally introduce myself.

I am currently Chairperson of the County of San Diego Regional Advisory Board on HIV/AIDS Housing Committee, Chairman of the HIV-Care Coalition, Outreach/Public Relations Committee and have been instrumental in public administration, health planning, public speaking, citizen advocacy and public issues that surround HIV/AIDS needs within the Hispanic Community. I am also in the process of trying to establish a non-profit Latino HIV-AIDS Community-Based Organization.

As a Hispanic/Latino individual, I feel it is crucial to address the needs in meeting HIV prevention and to take into account the impact of cultural issues, problems and barriers in meeting HIV/AIDS prevention needs within the Hispanic Community.

I would like to express my appreciation to two of your staff: Jeff Wynne and Steven Eldred for taking the time to listen actively and respond to issues, problems and barrriers in meeting HIV/AIDS within the Hispanic/Latino Community. Both Jeff and Steve, while maintaining a high level of performance and professionalism, have demonstrated their awareness to share an individual's world view without critically judging this view.

I urge you to assist me as rapidly as possible in educating health care professionals and others about the range and scope of these issues.

Enclosed for your review is some background on the mentioned concerns. If you should have any immediate questions about the enclosed, please do not hesitate to call me at (619) 296-7907.

Sincerely,

Victor M. Sanchez

Victor Montalvo Sanchez

(Sponsored by Victor M. Sanchez, Ind/living w/AIDS & SSI. Not eligible for medi-cal, responsible for medical health ins.premiums having to sacrafice auto insurance for survival)

cc: Mayor Susan Golding
Councilman Juan Carlos Vargas 8th District
Robert K. Ross, M.D., Director, County of San Diego Dept. of Health Services
Ms. Kristine Gebbie, National AIDS Policy Coordinator (Washington DC)
The Honorable Donna Shalala, Secretary of the Department of Health and Human Services
Mr. Frank Panarisi
Ms. Sandra Johnson
Congresswoman Maxine Waters 35th District, California c/o Constance Miller, Lesgislative Assistant
Constance A. Morella Member of Congress Eighth District, Maryland c/o Cynthia A. Hall, Legislative Director
Representative Nydia Velazquez (NY)
Representative Norman Mineta (CA)
Representative Bill Richardson (NM)
Faye M. Drummond, Senior Health Counsel, Senate Finance Committee Washington, DC
Cecilia Munoz, Senior Immigration Policy Analyst, NATIONAL COUNSEL OF LA RAZA, Washington, DC
Nicolas Parkhurst Carballeira, Director, Instituto de SALUD LATINA
Miguelina Maldonado, Executive Director, HISPANIC AIDS FORUM
Heriberto Sanchez-Soto, MSW, Executive Director, PROCEED, INC.
Marcia Ochoa, Housing Coordinator, Southeastern Connecticut AIDS Project
Maria Gonzalez, Servicios para el SIDA de Dallas
Allan Stinson, Project Director, THE RAFIKI SERVICES PROJECT
Ms. Rachel Ortiz, Executive Director, Logan Barrio Station Center
Jeff Wynne & Steven Eldred, Office of AIDS Coordination
Rich Juarez & Chuck Flacks, MAAC Project
Paul Akio Kawata, National Minortiy AIDS Council & Board of Directors, Washington, DC
The AIDS Chaplaincy Executive Committee & Rev.Vaughan Lyons
The HIV-Care Coaltion & The Planning Council (Dan O'Shea, Larry Johnson)
Marco Flores, PACTO, Alan Brown, MFCC, Advisor and Board of Directors
The Center for Social Concerns
Being Alive Board of Directors
Allen Kohler & Hank Ramirez
Guy de Voss & Roxanna Menes

CULTURAL SENSITIVITY

By Victor Montalvo Sanchez

The San Diego region has the distinction of sharing its southern boundary with Mexico. The three legal ports of entry between California and Baja California experience the highest volume of vehicle and pedestrian traffic in the world. The relationship between these two countries involves a contrast exchange of people products. The mutual interdependence of these countries, social, economics, and spiritual support, results in the sharing of health conditions. The binational health experience history of this region demonstrates that health issues do not respect geographic or political boundaries and mandates.

It is critical that HIV/AIDS be addressed from a binational perspective to assure that the efforts to fight HIV/AIDS at all levels be it education, testing, treatment care, and spiritual support.

Effective spiritual support must also be taken into account the impact of culture. Culture, is quite simply, the values and behavior shared by a group of individuals. It is important to remember that culture does not refer just to an ethnic or racial heritage. It can also be determined by age, gender, lifestyle**, or socioeconomic status. CULTURAL DIVERSITY is a fact of life in today's International "global village". Spiritual support representatives cannot afford to ignore the issues of culture**. The need for spiritual support guidance counselors to develop an increased awareness of their own cultural values and personal assumptions so that we can work sensitively with differences in age, gender, race, religion, ethnic background, and

AUTHENTICITY OF COMMUNITY BASED ORGANIZATION

By Victor Montalvo Sanchez

The authenticity of CBO's (Community Based Service Providers) is an intimate form of learning, demanding a CBO provider who is willing to shed stereotyped roles and be a real person in a relationship to the community. It is precisely within the context of such a person-to-person relationship that people experience growth. If as CBO's representatives we hide behind the safety of our professional role, our clients keep themselves hidden from us. If CBO representatives merely become technical experts and leave our own reactions, values, and self out of our work, the results of will be sterile in meeting the needs within the Latino community.

It is through our own genuineness and our aliveness that we can significantly touch Latino clients who placement is sometimes denied with AIDS purely on the basis of their diagnosis. Those who do go home occasionally return shortly, after having been cast out by their families, peers, co-workers, community based organizations, and religious organizations. At times even the gay and lesbian community discriminates against those Latinos affected with HIV/AIDS. In some cases, certain medical personal refuse to have anything to do with Latino clients suspected of having AIDS. A few medical workers perceive the situation to be "hopeless", and as a result, less aggressive diagnostic and therapeutic plans may be undertaken as Latino patients return with new infections.

Sometimes Latino clients have done well for prolonged periods. These "fortunate" survivors have been followed up closely by physicians with treatment begun at the earliest sign of deterioration. *Families of these long survivors generally have a strone commitment to their care, nutrition, and "spiritual support" not realizing that CBO's providers within the community have not only misrepresented them but have been contributors to fostering "self worthlessness".* ***Latino patients themselves lose interest in their condition and among hospitalized patients with AIDS, several develop a loss of interest in human contact, hiding beneath their bedsheets.***

We are all fully aware of uncertain infections nature of AIDS and the frightening implications it may have. When reasonable precautions are followed, there is no reason to subject AIDS patients to the intense ***SOCIAL and PSYCHOLOGICAL*** isolation some now experience.

If CBO providers make life-oriented choices, radiate a zest for life, are real in our relationship with Latino clients, and let ourselves be known to them, ***we can inspire and teach them in the best sense of the words.*** This does not mean that we are self-actualized persons who have "made it" or that we are without our problems. Rather, it implies that we are willing to look at our lives and do what is necessary to make the changes we want. Because we have a sense of hope that ***changing is worth the risk and the efforts,*** we can hold out hope to Latino clients that they have the capacity to become their own person and to like the person they are becoming.

* *Effective CBO's have an identity.* They know who they are, what they are capable of becoming, what they want out of life, and what is essential. Although they have a clear sense of their priorities, they are willing to reexamine their values and goals. They are not mere reflections of what others expect or want them to be but strive to live by internal standards.

* *They are able to recognize and accept their own power.* They feel adequate with others and allow others to feel powerful with them. They do not diminish others and allow others so they can feel a relative sense of power. They use their power and model its healthy uses in recognizing the needs of working with Latino/African Americans, but they avoid abusing it.

* *They are open to change.* Rather than settling for less, they extend themselves to become more. They exhibit a willingness and courage to leave the security of the known if they are satifsfied with what they have.

* *They are expanding their awareness of self and others.* They realize that if they have limited awareness, they also have limited freedom. Instead of investing energy in defensive behaviors designed to block out experiences.

* *They are willing and able to tolerate ambiguity.* Most of us have a low threshold for coping with a lack of clarity. Because growth depends on leaving the familiar and entering unknown territory. CBO's who are committed to personal development are willing to accept some degree of ambiguity in their lives.

* *They can experience and know the world of the people being served, yet their empathy is nonpossessive.* They are aware of their own struggles and pain, and they have a frame of reference for identifying with others while at the same time not losing their own identity by overidentifying with others.

* *They are authentic, sincere and honest.* They do not live by pretenses but attempt to be what they think and feel. They are willing to appropriately disclose themselves to selected others. They do not hide behind masks,defenses, sterile roles, and facades.

* *They make mistakes and are willing to admit them.* Although they are not overburdened with guilt over how they could or should have acted, they learn from mistakes. They do not dismiss their errors lightly, yet they do not choose to swell on misery.

* *They appreciate the influence of culture.* They are aware of the ways in which their own culture affects them, and they have a respect for the diversity of values espoused by other cultures. They are also sensitive to the unique differences arising of social class, race, and gender.

* *They have a sincere interest in the welfare of others.* This concern is based on respect, care, trust, and a real valuing of others. It is possible for CBO providers to disagree individuals values and still accept him or her as a person.

Personally, I think that we deceive ourself when we contend that our own personal experiences, values, beliefs do not enter into people relationships and that CBOs believe they do not have an influence on the people they serve on decision making and behavior.

It behooves me to clarify my position as an individual Latino, Gay, catholic, who currently serves as Chair of the San Diego Regional Advisory Board HIV/AIDS Housing Committee, Chair of the HIV-Care, Outreach/Public Relations Committee, who has been innstrumental in public administration, health planning, housing, public speaking, citizen advocacy, public policy, and issues, problems, and barriers in meeting HIV/AIDS prevention needs within the Hispanic Community to have experienced discrimination within the community based organizations in trying to address such issues.

BELIEFS AND ATTITUDES

* They are aware of their own values, attitudes, and biases and of how these are likely to affect minority clients. I would recommend that as a check on this process, they monitor their functioning through consultation, supervision and education.

* They can appreciate diverse cultures; they feel comfortable with differences between themselves and the community they serve in race and beliefs.

* ***They have the capacity to share an individual's world view without critically judging this view.***

* They are sensitive to circumstances (*such as personal biases and stage of ethnic identity)* That call for referral of the minority client to a member of his or her own race or culture.

KNOWLEDGE OF MULTICULTURALLY CBOs

* They understand the impact of oppression and racist concepts on HIV/AIDS, mental-health and on their personal and professional lives.

* ***They are aware of institutional barriers that prevent minorities from*** *making use of psychological services in the community.*

* They are aware of basic characteristics of CBO's that cut across classes and cultures and influence of CBO process.

* They posses specific knowledge about the historical background, traditions, and values of the group they are working with.

Efective multicultural CBOs practice and demand an open stance on flexibility, and a willingness to modify strategies to fit the need and the situations of the individual. CBOs who truly respect their community needs will demonstrate a willingness to learn from them. Understanding universal human themes (such as loneliness, fear, and psychological pain) *is as important as understanding cultural themes*. It is not always by similarity, but rather by differences, that we are challenged to look at what we are doing.

Effective CBOs must take into account the impact of culture. Culture is, quite simply, the values and behavior shared by a group of individuals. It is important to remember that culture does not refer just to an ethnic or racial heritage. It can also be determined by age, gender, lifestyle, or socioeconomic status. Cultural diversity is a fact of life in today's international "global village". CBOs cannot afford to ignore the issue of culture.

In order to work effectively with these new groups CBOs need multicultural training that emphasizes differences in the behavior of those seeking help, including differences in perceptions of mental health. CBO's hoping to address the needs of individuals who are culturally different from them must develop a basic respect for these individuals' experiential world. In the process of becoming more open to the client's world.

CONCLUSION:

Graduate programs have been accused of dealing, inadequately with mental-health issues of certain ethnic, and other cultural groups. Too often, minority-groups issues have been studied from a White, male, middle-class perspective.

Casas (1986) contends that traditional counseling programs have ignored the existence of ethnic minorities and have *ethnocentrically* assumed that the education and training provided could be applied to all groups. It is his view that most counseling students and instructors are not aware of their *culturally biased-values and attitudes*. He recommends that counselor-education programs, devote more attention addressing directly ethnic and cultural variables.

CBOs cannot afford to be deficient in multicultural knowledge and skills. CBOs have an obligation to provide services to individuals that meet their cultural preferences.

SAN DIEGO COUNTY REPORTED RESIDENT CASES OF AIDS
AS OF JANUARY 11, 1994

AIDS CASES BY TRANSMISSION CATEGORIES:
TRANSMISSION CASES BY CATEGORIES:

Transmission categories	**makes**	**fem**	**Total**	**%**
Homosexual/bisexual Men	4175	0	4175	79
Homo/Bisexual IDU	415	0	415	8
Injection Drug Use (IDU)	258	90	348	6
Homophiliac	35	2	37	<1
Heterosexual Contact	54	124	178	3
Transfusion with Blood/Products	65	65	110	2
Parent at Risk/Has HIV/AIDS	**14**	**11**	**25**	**<1**
Other	38	11	46	1
TOTALS	5,051	283	5,334	100

AIDS CASES BY ETHNIC GROUP:

Ethnic Group	**Cummulative#**	**%**
White	3909	73
Black	556	10
Hispanic	775	15
Asian/Pacific Islander	76	1
American Indian/Alaskan	18	0
Unknown	0	0
TOTALS	5,334	100

AIDS CASES and FATALITIES by YEAR of DIAGNOSIS:

Year	Number of Cases	Number of Death	%
1981	2	2	100
1982	4	4	100
1983	22	22	100
1984	46	46	100
1985	131	127	97
1986	240	227	95
1987	395	363	92
1988	560	483	86
1989	643	514	80
1990	729	531	72
1991	818	519	63
1992	1,001	332	33
1993	642	85	13
TOTALS:	5,333	3,265	61

NOTE: Data do not include persons who now live in San Diego County but were diagnosed elsewhere

DHS/AIDS & Community Epidemiology

June 25, 1993

Glen Allison
Chairperson
AIDS Chaplaincy Task Force
San Diego Ecumenical Conference
P.O. Box 34607
San Diego, CA 92163

Dear Mr. Allison:

A few weeks ago, a community activist came to me at AIDS Foundation San Diego with issues that he had about the functioning of your Board of Directors and it's impact upon the AIDS Chaplaincy Program. I shared those concerns with your Program Executive Consultant, in a brief informal note. I tried to impart that the award of a CARE Act contract to the AIDS Chaplaincy Program would make it accountable and vulnerable to public opinion regardless of motivation. Then, I put the matter out of mind. I have not received acknowledgement of the receipt of my note, although, not necessary.

To date I have been approached on two more occasions by individuals on the perceived function of your Board, search committee to fill the Volunteer Coordinator and issues of diversity. Today, I contacted Dr. Saylor, Executive Consultant inre my last communique and have been referred to you. It is my desire to make it clear that I am acting as an advocate of HIV services and as a community activist, not in the capacity of any of my affiliations. Recipients of Federal monies are accountable and vulnerable to public/ read consumer input. And, in fact I feel it is the responsibility of any AIDS service organization to include community and consumer input into the planning, design and implementation of service programs.

Who am I? I am currently, Secretary of the San Diego HIV CARE Coalition (HCC) of the Ryan White CARE Act Title II, member of the HCC contracts committee (which monitors the AIDS Chaplaincy Program contract with Title II, once signed), Director of Multicultural Diversity Programs at AIDS Foundation San Diego, President of the Board of Directors Being Alive San Diego, a person of color living with AIDS, former AIDS Walk San Diego Steering Committee member, Secretary of the African American Community Health Advocates, I consider myself a community advocate on issues which impact services to our PWHIV/PWAIDS, People of Color, Lesbian and Gay Communities.

I look forward to attending your next Board meeting to familiarize myself with your organization and I offer any assistance in my capacity. Thank you for your attention to this matter and best wishes.

Sincerely,

William Thompson

cc: D. Saylor, Ph.D.
Vaughan Lyons, SD Ecumenical Conference
Rick Siordian, Chair HCC Contracts

San Diego County Ecumenical Conference
AIDS CHAPLAINCY PROGRAM

Rev. Glenn Allison
Chair

June 28, 1993

TO: AIDS CHAPLAINCY PROGRAM, EXECUTIVE BOARD

FROM: Victor Montalvo Sanchez VMS
HIV Executive Board Representative
Chair, HIV-CARE Coalition, Outreach/Public Relations Committee

RE: **Cultural Sensitivity**

The San Diego region has the distinction of sharing its southern boundary with Mexico. The three legal ports of entry between California and Baja California experience the highest volume of vehicle and pedestrian traffic in the world. The relationship between these two countries involves a contrast exchange of people products. The mutual interdependence of these countries, **social, economics,** and **spiritual support,** results in the sharing of health conditions. The **binational health** experience history of this region demonstrates that health issues do not respect geographic or political boundaries and mandates.

It is critical that **HIV/AIDS** be addressed from a **binational perspective** to assure that the efforts to fight **HIV/AIDS** at all levels be it **education, testing, treatment care,** and **spirtiual support.**

Effective **SPIRITUAL SUPPORT** must also be taken into account the impact of **CULTURE**. **Culture** is, quite simply, the values and behavior shared by a group of individuals. It is important to remember that **culture** does not refer just to an **ethnic** or **racial heritage.** It can also be determined by **age, gender, lifestyle,** or **socioeconomic** status. **CULTURAL DIVERSITY** is a fact of life in today's International "global village." **Spiritual support representatives cannot afford to ignore the issues of culture.** The need for spiritual support guidance counselors to develop an increased awareness of their own cultural values and personal assumptions so that we can work sensitively with differences in **age, gender, race, religion, ethnic background,** and **lifestyle.**

P.O. Box 34607, San Diego, California 92103 □ (619) 294-7753

San Diego County Ecumenical Conference
AIDS CHAPLAINCY PROGRAM
August 20, 1993

Rev. Glenn Allison
Chair

TO: PACTO, Executive Board

FROM: Victor Montalvo Sanchez
AIDS Chaplaincy, HIV Executive Board Representative
Chair, HIV-Care Coalition, Outreach/Public Relations Comm.
Regional Advisory Board on AIDS/HIV Housing

RE: **The Psychosocial Impact of AIDS**

Absent in the flurry of publications about the current epidemic of **AIDS** is reference to the **PSYCHOSOCIAL IMPACT** of this devastating syndrome. A large portion of **AIDS** population is indigent and unable to obtain requisite outpatient care. Many patients studied thus far have shown evidence of protein-calorie malnutrition and multiple vitamin deficiencies. Once discharged, they can neither eat well enough to bolster their deficient nutritional state nor afford the many drugs required for their multiple infections.

Placement is sometimes denied to patients with **AIDS** purely on the basis of their diagnosis. Those who do go home occasionally return shortly, after having been cast out by their **families, peers, co-workers,** and **religious** organizations. At times even the **gay** and **lesbian** community discriminates against those affected with **HIV/AIDS**. In some cases, certain **medical personnel** refuse to have anything to do with patients even suspected of having **AIDS**. A few medical workers perceive the situation to be **"hopeless"**, and, as a result, less aggressive diagnositic and therapeutic plans may be undertaken as patients return with new infections.

Sometimes patients have done well for prolonged periods. These longer survivors have been followed up closely by physicians with treatment begun at the earliest sign of deterioration. Families of these long survivors generally have strong commitment to their **care, nutrition**, and **spiritual support.**

Patients themselves often lose interest in their condition and among hospitalized patients with **AIDS**, several develop a loss of interest in **human contact, hiding beneath their bedsheets.**

We are all fully aware of the uncertain infectious nature of **AIDS** and the frightening implications it may have. When **reasonable precautions** are followed, there is no reason to subject **AIDS** patients to the intense **SOCIAL** and **PSYCHOLOGICAL** isolation some now experience.

It is important for **AIDS** patients to have confidence in a strong **medical, family,** and **spiritual support** that will not abandon them as they face a **potentially life-threatening disease.**

P.O. Box 34607, San Diego, California 92103 □ (619) 294-7753

Ms. Kristine Gebbie
NATIONAL AIDS POLICY COORDINATOR
200 Independence Ave., SW Room 738G
Hubert H. Humphrey Building
Washington, DC 20201

Dear Ms. Gebbie:

The San Diego region has the distinction of sharing its southern boundary with Mexico. The three legal ports of entry between California and Baja California experience the highest volume of vehicle and pedestrian traffic in the world. The relationship between these two countries involves a contrast exchange of people products. The mutual interdependence of these countries, social, economics, and results in the sharing of health conditions. The binational health experience history of this region demonstrates that health issues do not respect geographic or political boundaries and mandates.

It is critical that HIV/AIDS be addressed from a binational perspective to assure that the efforts to fight HIV/AIDS at all levels be it education, testing also take into account the impact of culture within HIV/AIDS community based organizations.

Absent in the flurry of publications about the current epidemic of AIDS is reference to the issues, problems, barriers and psychosocial impact of this devastating syndrome in meeting HIV prevention needs within the Hispanic community. A large portion of the Hispanic population is indigent and unable to obtain requisite outpatient care. Many patients studied thus far have shown evidence of protein-calorie malnutrition and multiple vitamin deficiencies. Once discharged, they can neither eat well enough to bolster their deficient nutritional state nor afford the many drugs required for their multiple infections.

Placement is sometimes denied to patients with AIDS purely on the basis of their diagnosis. Those who do go home occasionally return shortly, after having been cast out by their families, peers, co-workers, and religious organizations. At times even the gay and lesbian community discriminates against those affected with HIV/AIDS. In some cases, certain medical personnel refuse to have anything to do with patients even suspected of having AIDS. A few medical workers perceive the situation to be "hopeless", and, as a result, less aggressive diagnostic and therapeutic plans may be undertaken as patients return with new infections.

Sometimes patients have done well for prolonged periods. These longer survivors have been followed up closely by physicians with treatment begun at the earliest sign of deterioration. Families of these long survivors generally have strong commitment to their care, nutrition, and spiritual support.

Patients themselves often lose interest in their condition and among hospitalized patients with AIDS, several develop a loss of interest in human contact, hiding beneath their bedsheets.

We are all fully aware of the uncertain infectious nature of AIDS and the frightening implications it may have. When reasonable precautions are followed, there is no reason to subject AIDS patients to the intense social and psychosocial isolation some now experience.

It is important for AIDS patients to have confidence in a strong medical, family, spiritual support and National AIDS Policy Coordinator that will not abandon them as they face a potentially life-threatening disease.

Who am I? I am a Hispanic living with AIDS and currently, Chair, San Diego Regional Advisory Board, HIV/AIDS Housing Committee, Chair, HIV Care, Outreach/Public Relations Committee who has been instrumental in health planning, public administration, public speaking, housing, community organization, and citizen advocacy and Hispanic leader living with AIDS who truly believes and supports your leadership as the National AIDS Policy Coordinator.

As an active Hispanic leader living with AIDS and advocate for issues, problems and barriers in meeting HIV prevention needs within the Hispanic community, I am very disappointed in not having had the opportunity to personally meet you and thank you for writing to me on September 17, 1993.

Sincerely,

Victor Montalvo Sanchez

/enclosure

PACTO LATINO AIDS
ORGANIZATION

AIDS CHAPLAINCY
3916 Normal St.
San Diego Calif. 92103
c/o Cindy Davis
AIDS Chaplaincy Coordinator

August 25, 1993

Ms. Davis

As a representative of Pacto Latino AIDS Organization; I would like to congratulate you on your new position as AID Chaplaincy Coordinator. You have my fullest support and vote of confidence as you assist the HIV infected and affected communities.

At Pacto, we work closely with the Latino monolingual community impacted by HIV and AIDS and our needs are many.
We would like to take this opportunity to request your assistance in providing us with the availability of a bilingual spiritual counselor of Catholic Faith placed with PACTO four hours per month.

We feel this effort would assist the spiritual needs of our clients.

Please feel free to call me with any question; We hope that you would be able to assist us with this endeavor.

Sincerely Yours,

Marco C. Flores M.P.A.
294-6622
P.O. Box 84027
San Diego 92138

C.C. Victor Sanchez
Alan Brown M.F.C.C. Advisor/Pacto

February 16, 1994

Mr. Frank Panarisi, Chairman
Mercy Hospital Board of Directors
4077 Fifth Avenue
San Diego, California 92103

Dear Mr. Panarisi:

Many thanks to you and Dr. Israel for taking the time to listen actively and respond to the issues that surround housing needs within the Hispanic Community; this is especially important when working with People who have a terminal illness and who may be (or at least feel) disenfranchised due to the direct physical consequences of the illness, social stigmatization, overwhelming financial worries, and abandonment by family members.

I currently serve as Chairperson of the County of San Diego HIV Housing Committee, Chairman of the HIV-Care, Outreach/Public Relations Committee and have been instrumental in public administration, health planning, housing, public speaking, citizen advocacy and public policy issues that surrounds HIV/AIDS housing needs within the Hispanic Community.

Fiscally, the broad direction of the HOPWA program in San Diego County is to use HOPWA funds to serve more eligible consumers, at a slightly reduced level of support, than was previously the case. The adjustment was proposed in order to provide housing assistance to a larger number of people in order to provide housing assistance to a larger number who are HIV+. Conceptually, the broad direction of the HOPWA program in San Diego County is to develop a balance housing service delivery system. The balance approached emphasizes direct rental assistance (tenant-based and project-based), while also providing support for residential AIDS shelter and other forms of group housing.

Enclosed for your review is a draft of the HIV Housing Plan for San Diego County 1994-95 and HIV-Care Coalition, Outreach/Public Relations membership packet. I look forward to discussing HIV non-profit housing production with you. If you should have any immediate questions about the plan, please do not hesitate to call me (619) 296-7907 or Jeff Wynne, Office of AIDS Coordination, (619) 236-2662.

Again, thank you for your support on this issue.

Sincerely,

Victor Montalvo Sanchez
Chair, Regional Advisory Board on HIV/AIDS Committee

/enclosures

Victor Montalvo Sanchez
3621 Park Blvd., #A
San Diego, California 92103-4548

$0.98

Ms. Kristine Gebbie
National AIDS Policy Coordinator
200 Independence Ave., SW Room 738G
Hubert H. Humphrey Building
Washington, DC 20201