

HIV Impact

A Closing the Gap newsletter of the Office of Minority Health, U.S. Department of Health and Human Services

Faith-Based Programs Fight HIV/AIDS in Minority Communities

By Linda Quander, Ph.D.

Faith-based organizations are effective tools for HIV/AIDS education because experts find that most Americans value the power of prayer and/or claim religious affiliation. Jon Lacey, Rel.D., Chair of the Council of Religious AIDS Networks and Director of Michigan State University's AIDS Education and Training Center, said, "Religious and faith leaders have a trusted, time-honored role in communities; many persons look to their churches, synagogues, temples or houses of worship for information and guidance in their lives."

State agencies such as the New York State Department of Health find religious institutions to be "ideal settings" for HIV/AIDS education because they reach people from all walks of life. They also communicate health information to hard-to-reach populations. For example, Rev. Rodney DeMartini, Executive Director of the National Catholic AIDS Network, said that as a part of their multicultural initiative, they are continuing to develop culturally appropriate HIV/AIDS educational materials, including translation of materials into Spanish. Lacey added, "Many of the frontline agencies fighting HIV and providing HIV/AIDS services were founded upon an interfaith base. Regional AIDS Interfaith Networks, or RAINs, continue in many places, even when other efforts falter."

Building faith-based and government partnerships

According to Yvonne Lewis, program specialist of the Centers for Disease Control and Prevention's (CDC's) Office of Minority Health, in 1997, CDC collaborated with the Congress of National Black Churches (CNBC) to convene a national summit attended by approximately 350 influential clergy and lay persons. The summit provided a forum for participants to explore issues of theology and practice that could empower congregations that minister to persons living with or affected by HIV/AIDS. She said, "As

a result of our partnership with CNBC, we are facilitating faith-based HIV/AIDS prevention education at the national, regional and congregational levels. In addition, we are partnering with the Interdenominational Theological Center at Atlanta University to develop a faith-based HIV prevention training curriculum for faith-based organizations and theological institutions."



For more than a decade, CDC's HIV Prevention Faith Initiative has supported the HIV/AIDS activities of faith-based partners. The Initiative's partners include the AIDS National Interfaith Network, the Balm in Gilead and the University of Texas School of Public Health and its subcontractor, Catholic Charities USA. The Balm in Gilead is endorsed by more than 17 major church denominations, caucuses and coalitions as well as independent churches. Through a cooperative agreement with CDC, it operates the Black Church HIV/AIDS National Technical Assistance Center, producing the HIV/AIDS Christian Education Curriculum and *Who Will Break the Silence: Liturgical Resources for the Healing of AIDS*.

Reaching the hardest to reach populations

Across the nation, faith-based health promotion efforts are trying to reach at-risk youth and others who are found on the street rather than in the church. Keeping It Real is sponsored by the interfaith group, Religious Coalition for Reproductive Choice in Washington, D.C. The program targets teens in discussing sexuality and AIDS prevention. In addition, the United Deliverance Church of God in Christ in West Palm Beach, Florida, recently received a \$49,000 grant from CDC to support its street outreach; especially at night, to drug addicts, prostitutes, teenagers and homeless people. Rev. AreNee Guthrie of the Glorified Word Ministries, Inc., in Milwaukee, Wisconsin, promotes outreach activities too.

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HIV Impact is a free quarterly newsletter of the Office of Minority Health, Office of Public Health and Science, U.S. Department of Health and Human Services. The Office of Minority Health Resource Center provides free information on various health issues affecting U.S. minorities.

To join our mailing list or to update your address, send an e-mail to info@omhrc.gov. Or, write to OMHRC, P.O. Box 37337, Washington, D.C. 20013. To submit story ideas or to comment on HIV Impact articles, contact Linda Quander, PhD, Senior Editor at the address above. E-mail: lquander@omhrc.gov

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Her church's, I Am My Sister's Keeper Annual Women's Conference allows women to come together to talk about sexuality and human wellness. Many attendees are from shelters for battered women, transitional living programs, alcohol and drug abuse programs, HIV/AIDS programs as well as the church community and other support groups.

Increasing communication strategies

In light of her experience as a radio broadcaster, Rev. Guthrie suggested "creating citywide advertising campaigns and programs especially designed for minorities and women." The Balm in Gilead has already used television commercials to get help from black churches. Dr. Bobby Jones, executive producer and host of Black Entertainment Television's (BET's) Bobby Jones Gospel and producer of BET's Video Gospel, has raised AIDS awareness and education not just across the nation but also around the globe.

At a Capitol Hill news conference in November, U. S. Surgeon General David Satcher, members of the Congressional Black Caucus and selected gospel artists announced the One Voice: Gospel Artists Respond to AIDS campaign. As a part of its efforts to dispel myths about AIDS, noted gospel artists will record a special CD featuring the song *One Voice*. The release of this song in the spring will coincide with a series of concerts in Washington, D.C., Los Angeles, and Chicago. Gospel artists will urge audiences to take HIV tests.

For more information about faith-based programs and HIV/AIDS in minority communities, see Resources on page 15, or call the OMH Resource Center at 1-800-444-6472. 

Connecting Body and Soul

Members of the faith community have a history of addressing racial disparities, including disparities in health. For example, the organizing force behind People United to Serve Humanity (PUSH) more than 25 years ago was in its Ministers' Division. As a part of the Rainbow/PUSH Coalition's 2000 convention, a forum on AIDS, "Ending the Silence: Ending the Epidemic," was held. During the live broadcast of this forum on Black Entertainment Television, ministers and their congregations were challenged to take HIV

tests to remove the AIDS stigma and to reduce HIV transmission among African Americans.

Rev. Ronald Weatherford, author of *Somebody's Knocking at Your Door: AIDS and the African-American Church*, has lost friends and family to AIDS. Interviewed at the October 2000 United States Conference on AIDS he said, "Throughout history, the black church has helped the community navigate storms of adversity. Now, the black church must be a beacon for high-risk groups and a lifeline for those stricken with AIDS." Rev. C.T. Vivian, Chair of the Center for Democratic Renewal in Atlanta, Georgia, was a keynote speaker at the conference. He said, "Church leaders will not really act until they see AIDS, like the civil rights movement, as a moral and spiritual fight." Weatherford added, "We have buried too many too soon. Saving souls is not enough. We must save lives as well." 

Publications

Activities for Individuals and Churches Developing HIV/AIDS Ministries. This fact sheet provides suggestions for organizations that are developing AIDS ministries. It encourages persons to lead their churches to join other concerned individuals and congregations. Available from the General Board of Global Ministries, United Methodist Church, Health and Welfare Ministries Program Department, 475 Riverside Drive, Room 350, New York, New York 10115. Call 212-870-3909.

Developing Your Church AIDS Policy. This manual provides assistance to churches that are developing AIDS policies. Available from AIDS Information Ministries, P.O. Box 13116, Fort Worth, Texas 76136. Call 817-237-0230.

Entrelanzando Nuestras Vidas -- Anecdotes de los que Amamos (Interlacing Lives -- Anecdotes from the Ones We Love). This publication provides information to members of the Hispanic community regarding AIDS. It discusses several theological considerations regarding AIDS and shares the stories of individuals and their families who have been affected by AIDS. Available from Catholic AIDS Ministry, P.O. Box 20325, Seattle, Washington 98102. Call 206-382-4885.

Contact the OMH Resource Center for additional publication information at 1-800-444-6472 or <http://www.omhrc.gov>. 

Universal Health Care Back On The Map In Congress

By Joel Segal, Legislative Assistant, Healthcare Specialist, Office of Congressman John Conyers, Jr.

The new Congressional Universal Health Care Task Force, founded by Congressman John Conyers, Jr., and the Congressional Black Caucus Health Braintrust, has gained the support of key democratic members of Congress; many of them senior members of the House. Representatives Pete Stark, Henry Waxman, David Bonior, David Obey, Barney Frank, Bernie Sanders, Jan Schakowsky, Peter Defazio, Patsy Mink, and 25 other representatives of the Progressive Caucus and Congressional Black Caucus are original co-sponsors of the Task Force.

The Congressional Universal Health Care Task Force is educating members and staff on various ways to achieve universal health care, and will work together to pass universal health care legislation in the next Congress. One of the main objectives of the Task Force is to “eradicate disparities in our health care system; in particular, those impacting the African American, Latino, and other communities of color.”

During the last session of Congress, Sen. Edward Kennedy introduced a bill, S. 3172, that would extend Medicaid to the nation’s 44 million uninsured. Companion legislation, HR 5551, the “Basic Health Plan Act,” was introduced in the House of Representatives by Dingell, Conyers, Stark, Waxman, Green, Brown, and Pallone. The bill would extend Medicaid to individuals who make up to 300% of the poverty level, and those above 300% would be able to buy into the program. This is a major breakthrough in Congress in that the “Basic Health Plan Act” would be the largest expansion of publicly financed health care since the 1960’s, and would create a system whereby the uninsured can receive health care coverage through Medicaid.

Both the Congressional Universal Health Care Task Force and the introduction of the Basic Health Plan could have a profound impact on the HIV/AIDS population. Senior democratic House leaders joining the Task Force shows that influential members of Congress are making a commitment to dis-

cuss and work on universal health care legislation—something that has not happened since 1994 when the ill-fated Clinton universal health care bill was being discussed in Congress. Providing Medicaid to all of the nation’s uninsured and increasing access to the health care system could dramatically decrease mortality rates and preventable diseases, including AIDS, in communities of color through access to early detection, screening, and health services.

An estimated 23% of African Americans have no insur-

ance at all. The rate is 1.5 times the uninsured rate for whites. While new treatment therapies have led to the recent decline in AIDS death rates, African-Americans continue to die from this disease at disproportionate rates. In 1997, Blacks and Hispanics accounted for 65% of AIDS cases. Race is a strong predictor of who will receive drug therapy for AIDS, with African-Americans 41% to 73% less likely than whites to receive particular drug therapies. In 1998, African Americans and Latinos accounted for two-thirds of the new AIDS cases. In 1997, Blacks and Hispanics accounted for 65% of AIDS cases.

According to the Kaiser Family Foundation, African

Americans are less likely than Whites to receive medical care or have surgical procedures that are known to increase life expectancy. The key to surviving AIDS is receiving life saving drugs early enough once the HIV virus has been diagnosed. There are countless individuals of color who are uninsured, and many have died prematurely of AIDS because they did not have access to high quality medical treatment, screening, and prevention services.

If you have questions about the Congressional Universal Health Care Task Force or the Basic Health Plan Act, please contact Joel Segal, Office of Congressman John Conyers, Jr., 202 225-5126, or Joel.Segal@MAIL.HOUSE.GOV. Or visit <http://www.u2kcampaign.org/taskforce.htm>. 

The work of the task force will focus on:

- Building a network of universal health care allies in Congress that will maximize the support of legislation to achieve health care for all.
- Working closely with health care justice organizations, networks and coalitions to achieve this goal, including the U2K Campaign.
- Making the issue of health care for all a vital issue in the 2000 elections.
- Promoting discussion and debate among members of Congress and their staff about universal health care and alternative policy approaches towards this goal.
- Educating colleagues on racial and ethnic disparities in health care, and other health care injustices.

OMHRC Begins Training Series

OMHRC, the Office of Minority Health Resource Center, recently completed its first series of town meetings with community-based organizations and AIDS service organizations. Sessions in six cities - **San Francisco, Miami, Washington DC, Houston, Chicago, and New Orleans** - gave community groups a chance to discuss organizational challenges and needs, and helped resource center staff plan follow-up technical assistance offerings. Some 209 providers representing 125 community organizations that offer HIV/AIDS prevention, education, outreach, care, counseling and other support attended one-day events during the summer of 2000. Follow-up technical assistance began in the fall, and will continue throughout 2001.

"Between our first visit to a city to conduct a needs assessment and our return to provide training and resources, I see change and hope growing," said Oscar Lopez, director of OMHRC's HIV/AIDS services team. "We have seen concrete steps and outcomes from our training sessions. Coalitions are being mobilized, people are motivated, and there is increased cultural awareness among the service providers from the different agencies."

The first follow-up training session, *Building Healthy Organizations A Skills-Building Training*, was held at the Radisson Hotel in New Orleans, Louisiana, on October 11-12, 2000. Sixty-one people attended the two-day event. Among the topics presented were:

- Developing Culturally Competent Resources for Latinos;
- Sound and Effective Program Design: Staffing, Budgets and Marketing; and
- Grant Writing - How to Become a Millionaire Organization.

Members of the OMHRC Resource Persons Network provided interactive presentations. Special focus was placed on best model approaches for each topic. Creating new paradigm shifts for new and better ways of conducting outreach efforts by targeting hard-to-reach clients was especially important. There was also a lot of concern about how to retain staff at their current pay rate when private organizations are paying so much more to do less work.

The rise in HIV/AIDS infection in the Latino/Hispanic population was a growing concern. Many organizations were self-identifying as not being ready or equipped to handle this new population. Translation services and providing outreach workers and case managers who are culturally competent proved to be a huge concern.

As a result of the Skills Building Training, a group of attendees, mentored by OMHRC trainers, decided that they would share information, create training opportunities, and support each other's efforts. They decided to begin meeting monthly and have since held their first meeting on November 10, 2000 at (NO/AIDS) Task Force, the largest HIV/AIDS outreach and edu-

cation organization in New Orleans. As a result of this new collaboration, the first Latino Health Fair was held in New Orleans during World AIDS Day and a town hall meeting to determine the needs of Latinos was held in January with OMHRC's HIV/AIDS staff serving as facilitators.

On November 1-2, 2000, *Building Healthy Organizations A Skills-Building Training* was held at the First Universalist Unitarian Church, in San Francisco, California. Fifty-eight HIV service providers attended the two-day event. Among the topics presented were:

- Creating REAL Linkages With Communities of Color, and
- How to Diversify Your Funding Base.

Participants stated that more work needs to be done to find more innovative ways of targeting gay and bisexual men in the Asian community. The presenter of the plenary session "Creating REAL Linkages with Communities of Color" worked during and after the plenary session conducting one on one sessions to come up with effective ways to target the aforementioned population.

Participants also expressed a desire to create a web page about HIV services, programs, vacancies and announcements by and for the Bay Area. Since the San Francisco area has the largest number of HIV organizations in the country, many in attendance expressed concern about overlapping services and trying to track too many events. The facilitators asked the Asian and Pacific Islander (API) Wellness Center, a community based organization savvy in web design and its uses, if they would take a lead on this project because they possess the infrastructure and manpower to handle such a task.

A meeting with all interested parties is scheduled to take place early in 2001, and everyone who expressed an interest in the collaboration project shared his/her contact information on site. The API Wellness Center volunteered to serve as the coordinator and host for the initial meetings; the Office of Minority Health Resource Center - HIV Training Team committed to support their efforts to get this project up and running.

"Many people have come up to us and said that they appreciate the Office of Minority Health's willingness to listen to their concerns and take immediate and culturally competent action," said Lopez. "There is much more to do, but it is exciting to see the possibilities." 

For more information
on the upcoming dates for the
"Building Healthy Organizations," trainings,
see *In Other HHS News* on page 5,
or contact the OMH Resource Center at
1-800-444-6472, ext. 235.

Minority Health Advisory Committee Appointed

In December 2000, HHS Secretary Donna E. Shalala announced the appointment of 12 members to the Secretary's new Advisory Committee on Minority Health. The committee will advise the Secretary on ways to improve the health of racial and ethnic minority populations, and on the development of goals and program activities within the department.

"I am pleased that these experts have agreed to share their insights with us," Secretary Shalala said. "Their advice will be invaluable in helping us achieve our goal of eliminating racial and ethnic disparities in health."

The advisory committee, created by the Health Professions Education Partnerships Act of 1998, will be chaired by Louis Stokes, a lawyer, a former congressman from Ohio, and a former chairman of the Congressional Black Caucus. The 12 committee members have expertise on a wide range of health issues including the unique challenges facing minorities in rural and urban communities, children, women, elders, people with disabilities, mental illness and AIDS. The committee will meet four times a year.

The new members come from eight states, the District of Columbia and one U.S. Pacific territory. The committee includes three members each from the Black/African-American, American Indian and Alaska Native, Asian American and Pacific Islander, and Hispanic/Latino communities.

The department is two years into its signature effort to address minority health through the President's plan to eliminate racial and ethnic disparities by the year 2010, starting with a focus on six key areas: infant mortality, diabetes, cardiovascular disease, cancer screening and management, HIV/AIDS, and childhood and adult immunizations.

For more information contact the Office of Minority Health at 301-443-5224. 

In Other HHS News

■ **HHS Announces National Standards for Patient Medical Records:** "For the first time, all Americans -- no matter where they live, no matter where they get their health care -- will have protections for their most private personal information, their health records," Secretary Shalala said in a December 2000 press release regarding the nation's first-ever standards for protecting the privacy of Americans' personal health records. This new regula-

tion will protect medical records and other personal health information maintained by health care providers, hospitals, health plans and health insurers, and health care clearinghouses. *For more information on the new standards, a fact sheet on this subject is available at <http://www.hhs.gov/news/press/2000pres/00fsprivacy.html>* 

■ **NIH Establishes New Research Centers:** The National Institutes of Health announced plans to establish two more Centers for Dietary Research in September 2000. The Centers will be located at Purdue University and the University of Arizona at Tucson. Funding will be provided by the Office of Dietary Supplements (ODS) in collaboration with the National Center on Complementary and Alternative Medicine (NCCAM). The awards are for approximately \$1.5 million each year for five years. 

OMHRC HIV/AIDS Services Training Schedule 2001

<i>"Building Healthy Organizations" Training</i>	
Miami, FL	2/12-13
Washington, DC	3/27-28
Houston, TX	4/10-11
Chicago, IL	4/24-25

Advisory Committee on Minority Health

Dr. Isamu Abraham
public health official,
Department of Public Health,
Saipan, Commonwealth of the Northern
Mariana Islands

Mr. Salvador Balcorta
social worker and chief executive officer,
Centro de Salud Familiar La Fe, Inc.,
El Paso, TX

Dr. Henry Chung
physician, Chinatown Health Clinic,
New York, NY

Dr. Estevan T. Flores
sociologist and journalist, Latino/a Research
and Policy Center, Denver, CO

Dr. Theodore Mala
physician and public health expert, Office of
Village Initiatives, Southcentral Foundation,
Anchorage, AK

Dr. Clyde Oden
optometrist and health services executive,
Watts Health Foundation, Inglewood, CA

Dr. Joan Reede
physician and educator, Harvard Medical
School, Boston, MA

Dr. Yvette Roubideaux, clinical assistant
professor, University of Arizona, College of
Public Health, Tucson, AZ

Ms. Delight Satter
senior public health researcher and policy
manager, UCLA Center for Health Policy
Research, Los Angeles, CA

Mr. Louis Stokes
attorney at law and former congressman,
Washington, DC, who will chair the
committee

Dr. Ho Tran
physician and state health official, Illinois
Department of Public Health, Chicago, IL

Dr. Antonia Villarruel
nurse and educator, University of Michigan
School of Nursing, Ann Arbor, MI

Depression, Anxiety, and HIV/AIDS

By Linda Quander, Ph.D.

According to experts, depression is often related to the notification of HIV-positive status; beginning of treatment; and the onset of symptoms, opportunistic infections and AIDS-defining conditions. Major depression must be treated in order to avoid an increase in risk behaviors and hospital stays as well as a decrease in adherence to treatment, quality of life, and survival.

Risk behaviors. In a study published in the March 2000 issue of the *Archives of Pediatrics and Adolescent Medicine*, researchers at the Children's National Medical Center in Washington, D.C., found that HIV-positive teens had a high prevalence of major psychiatric disorders, including depression, substance abuse, and conduct disorder. The researchers proposed mental health problems put these teens at greater risk for high risk sexual behavior and substance abuse.

Annelle Primm, M.D., Associate Professor of Psychiatry at Johns Hopkins University's School of Medicine, said, "People with depression don't always understand its impact on their judgment. Not protecting themselves sexually, eating improperly, and using alcohol and drugs improperly place them at increased risk for HIV/AIDS." Conditions leading to an increased exposure to diseases can be related to a reduced ability to resist infections.

Inpatient care. In the May 2000 issue of the *Journal of General Internal Medicine*, Rutgers University researchers reported that HIV patients with depression but treated with antidepressants had lower monthly costs for medical care, including inpatient services. In addition, there was a significant increase in the number of mentally ill chemically addicted (MICA) patients with HIV. Problems with their preventive care and delays in the diagnosis of HIV-related illnesses resulted in their dependence on inpatient services.

Adherence to treatment. Mental health and social support services can enhance adherence to AIDS treatment. Health care providers can destigmatize feelings about treatment failures, allowing patients to believe that they can overcome setbacks. In the March 2000 issue of *Health Psychology*, researchers from the Medical College of Wisconsin found AIDS patients were more likely to follow newer, more complex medication schedules if they were confident that they could. Nonadherent patients were more depressed than other HIV patients, reported more side effects, had lower confidence in their ability to follow the medication routine and reported less support from others. Gilbert Parks, M.D., a psychiatrist and former Chairman of the



Board of the National Medical Association, said, "Patients must have a trusting, reliable relationship with their health providers. Pills alone will not solve problems."

Suicide risk. Transient thoughts of suicide can occur before and after HIV antibody testing as well as throughout the disease course. Risk of suicide is especially high at the HIV-related milestones listed earlier. Individuals who are HIV-positive have more thoughts of suicide and attempt suicide more frequently than those without HIV infection. Suicide risk factors include:

- Abandonment by family, friends or significant others;
- Stigmatization due to HIV, sexual orientation or substance abuse;
- Social isolation;
- Perception of poor social support;
- Financial difficulty;
- Major HIV-related work problems;
- Fear of HIV-related dementia;
- Significant changes in health status; and
- Relapse into drug use after recovery.

Correlations between anxiety and AIDS. Mild anxiety to full-blown panic attacks can accompany HIV/AIDS in relation to uncertainties about the disease and treatment. HIV antibody testing can produce anxiety among many individuals, especially among those who have engaged in high risk behaviors. On the other hand, refusing to take an HIV test has also been related to anxiety.

Some who refuse to be tested believe that they could not cope with test results. Both positive and negative HIV antibody test results can be stressful. Experts find many HIV negative men who have sex with men are "worried well." They feel guilt and anxiety about surviving the AIDS epidemic.

There are a growing number of studies on stress-related effects on HIV progression. Research documents that psychological stress is linked to the ability of the immune system to function. Studies supported by the National Institutes of Health's Mind-Body Research Centers will add to the improved understanding of the nature of this relationship. The centers focus on research that seeks to understand how beliefs, attitudes, values and stress affect physical and mental health.

For more information about depression, anxiety and HIV/AIDS, see Resources on page 15, or call the OMH Resource Center at 1-800-444-6472. 

Let's Talk:

Answers to Your Questions About Cultural Competency

By Linda Quander, PhD.



In the first issue of *HIV Impact*, we asked for feedback in order to understand your needs. Since last spring, we have received numerous requests for information about culturally competent HIV/AIDS services. Part one of this article is below, and

Part 2 will appear in the Spring 2001 issue. Part 2 will include case studies and best practices. Here are answers to your real questions from some experts:

Q: How can healthcare professionals become more culturally competent?

Assess yourself.

A: Joanna Su, Executive Director of the Asian Health Coalition of Illinois, said:

“Some people may think about cultural competence only in terms of learning about various ethnic groups, and certainly this is an important part of it. But it also means that providers should first be aware of their own cultural backgrounds and the assumptions that they make based on their cultural heritage. Otherwise, providers may assume that everyone looks at things from the same standpoint as they do.”

Avoid stigmas and stereotypes.

A: Joan Ferguson, Community Coordinator for Blacks Assist-ing Blacks Against AIDS in St. Louis, Missouri, said:

“The healthcare professional must avoid using labels (junkie, homosexual, prostitute, addict, boy, girl, you people, etc.) because this language is alienating and accusatory. Certain pictures come to mind when those words are used, and if the client doesn't see himself in that picture, he won't see himself as being at risk.

Also, avoid statistical data. It's too far removed from the client's reality. Who is the CDC, WHO, FDA, etc.? The client may not know and probably doesn't care. Some people suspect the government is responsible for this disease devastating communities of color, so the last thing they want to hear is what “the man” (government) has to say.”

Promote effective communication.

A: Robert Like, M.D., Director of the Department of Family Medicine at the Center for Healthy Families and Cultural Di-

versity, Robert Wood Johnson Medical School in New Jersey, said:

“Every clinical encounter is a cross-cultural encounter, and we need to be open to learning to listen to each and every patient's unique perspective. We should not live in a world of ‘cookbook medicine.’ We need to learn about where our personal and collective blind spots are, and this often means asking others and being receptive to feedback.”

Joan Ferguson added:

“It is very important for the healthcare professional to listen to the client and to meet the client where he is. It is important to understand the client's language, both spoken and unspoken (body language: eye contact, or lack of, rolling and shifting of eyes, crossing of arms, a down head, etc.). This conveys whether the client understands his perceived risk, is in denial about his positive status or is clueless as to what the healthcare worker is talking about.”

Dismantle language barriers.

A: Brian Gibbs, Ph.D., Director of the Program to Eliminate Health Disparities at Harvard University's School of Public Health, Division of Public Health, said:

“Being open to the formal learning of a new language, and/or having one's own patients teach them a new language are also ways that we, as healthcare professionals, can improve skills in cultural competence.”

Joanna Su added:

“In many immigrant and refugee communities, cultural competence also includes overcoming linguistic barriers. Providers should be aware that all healthcare provider institutions who receive federal funds (e.g. Medicaid) must offer qualified interpreters to their limited English speaking patients under Title VI of the Civil Rights Act of 1964. ‘Qualified interpreters’ means fluent bilingual individuals who have been trained in health interpretation.

If providers have any questions about how to provide this service, they can contact their local Department of Health and Human Services' Office for Civil Rights for assistance. Also, the Asian and Pacific Islander Wellness Center in San Francisco has produced an excellent publication, *Physician's Guide to Working with Asians and Pacific Islanders Living with HIV*, which identifies cultural factors and how to address cultural and linguistic barriers.”

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Creating Cultural Competency

In 1999, the Wisconsin HIV Prevention Community Planning Council, with consultation from Nara Smith Cox, Ph.D., Associate Professor at the University of Wisconsin at Madison, developed the Multicultural Competency Assessments. In 2000, the Academy for Educational Development, Centers for Disease Control and Prevention and National Alliance of State and Territorial AIDS Directors included them in *Bright Ideas: Innovative or Promising Practices in HIV Prevention and HIV Prevention Community Planning*.

The two sets of indicators were designed to reflect the practice of multiculturally competent HIV prevention by both individuals and agencies. The Council has found that these assessments are useful to those providing care and treatment too. Because these tools give a snapshot of multicultural competency at one point in time, it is suggested that the assessments be used repeatedly (annually, for example) to help individuals and agencies monitor their increasing ability to serve diverse individuals better. The self-assessment for individuals is printed below. The assessment for agencies will appear in the Spring 2001 issue.

How do you start?

Before beginning the multicultural assessment, it is important to determine the specific purpose and expected use of the results or discussion summaries by the organization. For example, an organization may use the assessment to:

- Foster initial discussion about multicultural issues;

- Guide development of departmental or individual work plans; or
- Develop recommendations for action by the Board of Directors.

In addition, it is important to answer “who?” will be involved. Again, there are many possibilities. The multicultural competency assessment may involve:

- All staff members in the prevention services department;
- Representatives from all levels of the organization;
- A sample of clients;
- A sample of volunteers;
- All staff; or
- All members of the Board of Directors.

The assessments are tools to support the work of the agency as it continually strives to increase effectiveness of its HIV prevention services. While the assessments were designed to guide group discussion, they can also be completed anonymously, collected, or summarized, after which the survey results could be used as a basis for discussion. Authors recommend using one of the approaches mentioned above, or modifying one of these approaches to better suit your needs.

For more information about the assessments, contact Dr. Cox at 608-262-2730 or nc6@mail.dcs.wisc.edu; or Molly Herrmann, Wisconsin HIV/AIDS Program, Community Planning Coordinator at 608-267-6730 or herrmann@dhfs.state.wi.us.

Multicultural Competency Self-Assessment for Prevention Service Providers

Multicultural competency is a commitment to: (a) exploring the influences of one’s own culture or cultures, (b) understanding ways in which groups of people have been, and are, treated in society, and (c) developing knowledge and skills to provide effective HIV prevention services for people who are diverse in terms of gender, age, race, ethnicity, sexual orientation, religion, HIV status, primary language, disability, etc. This survey provides a tool for you to assess your multicultural competency and to guide discussion among HIV prevention service providers about ways in which you can increase your effectiveness in providing HIV prevention services for diverse individuals.

Rate your level of multicultural competency on a scale from 1 (not at all) to 5 (extremely).

CULTURAL AWARENESS

a. I recognize the influence of my own culture(s) on my actions and thoughts.

1 2 3 4 5

b. I am aware of my life experiences as a person related to a culture (or multiple cultures.)

1 2 3 4 5

c. I have assessed my involvement with persons of other cultures.

1 2 3 4 5

d. I have contact with individuals, families and groups of people reflective of other cultures.

1 2 3 4 5

KNOWLEDGE

a. I am knowledgeable about the community, demographics, history, problems, and strengths of the social and cultural groups of individuals with whom I work.

1 2 3 4 5

b. I know that the diversity within cultures can be as important as diversity between cultures.

1 2 3 4 5

c. I am knowledgeable about the sexual cultures (and nuances of these cultures) of the individuals with whom I work.

1 2 3 4 5

d. I am knowledgeable about drug use in the context of sexual expression of the individuals with whom I work.

1 2 3 4 5

e. I am knowledgeable about the following factors and their relationship to HIV/AIDS prevention and risk behaviors:

racism	1	2	3	4	5
sexism	1	2	3	4	5
classism	1	2	3	4	5
heterosexism	1	2	3	4	5
homophobia	1	2	3	4	5
ageism	1	2	3	4	5
HIV status	1	2	3	4	5

f. I am knowledgeable about alcohol and other drug use related to HIV/AIDS among the individuals with whom I work.

1 2 3 4 5

g. I am knowledgeable about mental health related to HIV/AIDS among individuals with whom I work.

1 2 3 4 5

SKILLS

a. I express concern, interest, credibility and competence to the individuals with whom I work.

1 2 3 4 5

b. I show respect for the unique and culturally-defined strengths of various individuals.

1 2 3 4 5

c. I show respect for the unique and culturally-defined needs of various individuals.

1 2 3 4 5

d. I am able to work with the multiple roles and identities of individuals.

1 2 3 4 5

e. I am able to advocate for individuals (and on my clients' behalf).

1 2 3 4 5

f. I am able to identify resources, assets, and strengths within a community.

1 2 3 4 5

g. I am able to help clients personalize their risks of HIV transmission.

1 2 3 4 5

h. I am able to help individuals build upon their strengths to reduce HIV transmission risks.

1 2 3 4 5

COMMITMENT TO INCREASING MULTICULTURAL COMPETENCY

a. I have identified specific ways to increase my multicultural competence.

1 2 3 4 5

CONCLUSIONS

1. What are your strengths, or what do you do well, when working with people who are different than you?
2. What are your biggest challenges when working with people who are different than you? What makes you most uncomfortable?
3. What would be helpful to increase your comfort and ability to work effectively with people who are different?

Complementary and Alternative Medicine Research on HIV/AIDS

By Linda Quander, Ph.D.

The phrase “complementary and alternative medicine” (CAM) describes healing philosophies, approaches, and therapies that are not widely accepted, integrated, or practiced by the mainstream medical community. When used in addition to mainstream medical treatment, a therapy is most often identified as complementary. However, when a therapy is used instead of conventional treatment, it is labeled as alternative. Commonly used CAM therapies may include mind/body control interventions (e.g. relaxation, visualization), manual healing (e.g. acupressure, massage), homeopathy, vitamins or herbal products, and acupuncture.

According to an article from the 1999 Community Research Initiative on AIDS entitled “Complementary Medicine and HIV: The Research Dilemma,” research to evaluate the effectiveness of complementary therapies in treating HIV-related conditions remains rare in scientific literature. Most complementary medicine studies have been surveys, case studies, anecdotal accounts, or studies with small sample sizes. Research protocols commonly lack:

- Standard control due to the absence of comparable placebo techniques;
- Standard treatment due to CAM’s individualized treatment approaches;
- Standard, congruent terminology between Western and non-Western treatments; and
- Standard, validated outcome measures due to differences in acceptance of evaluation tools.

Strengthening the research agenda

The new White House Commission on CAM Policy will not set NIH’s National Center on Complementary and Alternative Medicine’s (NCCAM’s) research agenda, but it is charged with making recommendations concerning access, delivery, training, and licensure, as well as the development and dissemination of accurate, useful information. Significant increases in status, authority, and funding given to NCCAM by the U.S. Congress reflect a growing interest in CAM therapies.

Strengthening the scientific base for the assessment of CAM therapies for HIV research recognizes: their widespread use by HIV-positive individuals; their potential benefits and risks; and the perceptions of their effectiveness that may help or hinder use of conventional HIV therapies. As a result, NIH continues to invest in scientific evaluation activities such as those at Bastyr University’s AIDS Research Center, in Kenmore, Washington.

Including minorities in HIV-CAM research

NIH’s Ad Hoc Panel on CAM Therapies Research examined the problems of underserved populations in HIV-CAM research. During the May 2000 meeting of NCCAM’s Advisory Council, minority health disparities were discussed in relation to efforts to increase minority recruitment and retention in clinical trials. Because some non-mainstream practices have roots in minority cultures, several experts believed that minority patients might have a special interest in research on complementary and alternative medicine, which also may help to overcome their negative perceptions about medical research.

For more information about complementary and alternative medicine research on HIV/AIDS, see Resources on page 15, or contact the OMH Resource Center at 1-800-444-6472.

Technical Assistance on Alternative Therapies

The mission of the Health Resources and Services Administration’s Bureau of Primary Health Care (BPHC) is to increase access to quality comprehensive primary and preventive health care and to improve the health status of medically underserved populations. This includes providing access to complementary and alternative medicine (CAM) services for these populations. These services are increasingly becoming available options at BPHC-funded primary care service sites. The BPHC established the Integrative Medicine and Alternative Health Practices (IMAHP) Initiative to provide guidance and technical assistance integrating CAM with conventional primary care at BPHC-funded programs.

“To be culturally competent, it is necessary to integrate CAM therapies with conventional medicine and indigenous healing practices. When integrated with conventional primary care and traditional healing approaches, CAM therapies need to reflect the culture(s), including primary language(s) and housing status, of the communities served,” said Lanardo Moody, Acting Senior Advisor on Integrative Medicine and Alternative Health Practices at BPHC. In the following interview, Moody answers questions about why the IMAHP Initiative is important and how BPHC provides guidance on integrating CAM services and conventional primary care for the underserved.

Q: Why is it important to assess the needs of minority populations in providing access to CAM services?

A: It is important because there are no definitive data on CAM use by the underserved in this country. These populations are underrepresented in the current national data. More than 60 percent of BPHC’s service population is composed of persons that have traditional healing practices. Our service population includes persons with cultural origins in Asia, the

...continued on page 12

Evaluating Online Information

Internet sites specializing in complementary and alternative medicine are continuously increasing. While some provide useful information, others may be unreliable and potentially dangerous to consumers. These ten tips were taken from the National Cancer Institute's web advice to cancer patients in their search for health information on the internet. Answering these questions when visiting a site will also assist you in evaluating HIV/AIDS-related online information.

1. Who operates the site?

It should be easy for visitors to see who is responsible for the site and its information. Who runs the site should be clearly identified on every major page of the site, along with a homepage link.

2. What is the purpose of the site?

Who operates the site, and who pays for the site should be clearly stated. Go to "About this site" or "Mission Statement," which usually outlines this type of information.

3. What are the sources of information?

Complementary and alternative medicine sites typically post information collected from other websites or offline sources. If the site's organizer(s) did not create the information, then the original source(s) should be identified.

4. What is the basis of the information?

Medical facts and figures have references or the consensus of experts reviewing research results. Opinions and advice should be distinct from evidenced-based information.

5. How is the site information selected?

Consider the qualifications of the individuals who review the information before it is posted. Is there an editorial board?

6. How current is the information?

Information should be reviewed and updated regularly. Each major page should list "this page last updated on..." Although the information remains unchanged, it should be recently reviewed to guarantee validity.

7. How does the site select links to other resources?

Sites usually have a policy, even if unstated, about how they link to other sites. While some sites act conservatively and don't link to other sites, there are those who link liberally to any requesting or paying for a connection.

8. Who pays for the site?

Most sites have an outside source of funds which should be clearly identified on the site. Remember the funding source can affect selection and presentation of content as well as the purpose of the site.

9. What information about visitors does the site collect, and why?

In order to assess what pages are used, most site operators routinely track the paths visitors take through their information. When health websites ask visitors to become subscribers or members, they may be selecting information that is important to you, or they may be collecting a user fee. Credible sites will explain what they will and will not do with your personal information. Be absolutely certain that you examine privacy policy statements or language.

10. How does the site manage visitors' interactions?

There should be an easy and timely way to share problems, feedback and questions with site owners. If the site hosts chat rooms or online discussion areas, find out if this service is moderated as well as why and by whom. &

Still Unsure?

If you are still uncertain about complementary and alternative medicine information, use the U.S. Food and Drug Administration (FDA)/ State AIDS Health Fraud Task Force Network. Avoid fraudulent products and treatments by using their web pages. Go to:

AIDS Health Fraud Task Force of California
<http://www.aidsfraud.com>

Colorado HIV/AIDS Consumer Information Task Force
<http://www.rmi.net/citf/>

FDA/State AIDS Health Task Force Network
<http://www.fda.gov/oashi/aids/eval.html>

Florida AIDS Health Fraud Task Force
<http://www.applicom.com/tcrs/Fraud.htm>

Georgia AIDS Therapy Information Network
<http://www.gatin.com>

Michigan AIDS Fraud Task Force
<http://www.msms.org/resources/aft.htm>

Texas AIDS Health Fraud Information Network
<http://www.tahfin.org>

Schools Make A Difference in Fighting HIV/AIDS

According to Carol Bellamy, Executive Director of the United Nations Children's Fund (UNICEF), AIDS-ravaged countries should make greater use of schools in the battle against the epidemic. She finds that schools provide young people with information, develop their life skills, and can affect the care of those living with AIDS in their communities.



The most recent annual report by the Joint United Nations Programme on HIV/AIDS shows that there is an increase in condom use and a decrease in casual sex among African teenagers who attend school. For example, in Uganda, infection rates among educated women dropped by more than half between 1995 and 1997 due to comprehensive prevention programs. Since the United Nations' previous report, an additional 600,000 children acquired HIV and 500,000 died.

Their current report projects that in eight countries in sub-Saharan Africa, one-third of today's 15-year-olds will die of AIDS.

UNICEF's recent survey reveals that young people generally do not know how HIV spreads. In several countries, almost half of all 15 to 19-year-

old females did not know that a person who looks healthy can have HIV. Even in countries devastated by AIDS, nearly half of sexually active 15 to 19-year-old females believed that they were not at risk. Ironically, over half of adolescents could not name a single method of protection against HIV/AIDS. Most of the respondents who were not aware of ways to protect themselves were girls.

UNICEF challenges schools to deal with gender discrimination in fighting AIDS. Women are up to four times more likely to get HIV from men than men are from women according to their data. Because men have more power than women in most societies, the consequences of refusing sex – which include violence – seem more threatening to women than health risks. Therefore, UNICEF notes the World Health Organization's "Men Make a Difference" World AIDS Day theme. Both organizations believe that boys are important in changing gender bias and preventing HIV.

For more information, contact Ruchira Gupta with UNICEF New York at 212-326-7670 or e-mail rgupta@unicef.org.

Anti-AIDS Ads Cause Controversy in Zambia

This report includes information from the British Broadcast Corporation News and Reuters Health Information Service.

Zambian officials recently suspended health infomercials on HIV and condom use due to strong criticism from local church groups and some government circles. The advertisements targeted young people in an effort to deal with high rates of HIV infection. Zambia has one of the highest rates of HIV infection among all countries. The nation currently cares for 520,000 children orphaned by HIV, and the number is predicted to increase to 974,000 by 2014.

Church groups complained that the campaign encouraged promiscuity. Some clergy thought that there should be a focus on promotion of abstinence rather than on condom use. Ads were shown during a prime-time viewing slot. During that time period, many Zambian families found the frank nature of the discussion and demonstration about condoms uncomfortable. Despite the controversy, anecdotes by international news organizations reveal that the ads have caught on.

In Zambia, the fight against AIDS is financed primarily by international donors. Government officials have requested \$559 million from them for future programs. Many international donors have now voiced concerns over the suspension of the ads. 

Pacific Islands, Africa, Latin America as well as Europe.

Q: How does the IMAHP Initiative provide guidance and technical assistance to underserved communities?

A: IMAHP staff make presentations, conduct site visits, establish relationships with national CAM experts and institutions, and develop collaborative linkages within and outside of government with a focus on CAM and the underserved. The IMAHP Initiative has a legal advisor assigned to provide medical-legal guidance.

In addition, the bureau has issued an official Program Assistance Letter (PAL)-2001-01 entitled "Access to Complementary and Alternative Therapies" to all health centers that we fund. This letter gives direction on the selection of CAM modalities, privileging and credentialing for CAM providers, policies, procedures, and culturally and linguistically appropriate services.

Q: Why is it important to develop CAM outreach strategies to minority populations?

A: It is important because healthcare disparities exist among underserved populations. In addition, population projections for the United States in the latter part of this century indicate that racial and ethnic groups will ultimately exceed the majority population. Culturally diverse populations sometimes use the traditional healing practices as their principal method of health care.

Western conventional medicine is sometimes seen as the "alternative medicine." We need to ascertain utilization data and safety and efficacy data for these groups to both maintain health status and improve behavioral lifestyles. We hope to learn how to provide better health care to underserved populations with less cost and a reduction in health disparities.

For more information about complementary and alternative medical research on HIV/AIDS, see Resources on page 15, or call the IMAHP (Integrative Medicine and Alternative Health Practices) Initiative at 301-594-4241. 



Mentally Ill Patients Are at Greater Risk for HIV, TB, and Hepatitis

Dr. W.F. Piri of the Harvard University Medical School and the Eric Lindemann Mental Health Center in Boston, Massachusetts, presented findings that indicated patients in mental hospitals were at greater risk for HIV, tuberculosis and hepatitis than individuals in the general population. Research findings were discussed at the annual meeting of the Academy of Psychosomatic Medicine in November. More than 650 men and women admitted to psychiatric facilities between 1997 and 1999 were four to five times more likely to be infected with hepatitis B and 12 times as likely to have hepatitis C. Twenty percent tested positive for TB while the estimated rate of HIV was 3 percent.

More information will be available at <http://www.psychiatryonline.org> in early 2001. Look under *psychomatics*.&

Longitudinal Study Challenges Teen Risk Factors

A recent report suggests that race, income and family structure are not useful in attempting to predict self-destructive behavior among adolescents. School performance and spending a lot of unsupervised time with friends are better predictors of whether teens will drink, smoke, use weapons, attempt suicide or have sex at an early age, according to *Add Health*.

The ongoing longitudinal study began in 1994. Dr. Robert Blum, principal investigator, found that more than half of young Americans make good choices in their lives. However, some other findings are:

- Hispanic teens do not drink any more frequently than other teens.
- The single most significant predictor of whether teens engage in intercourse is an ongoing relationship.
- Virginity pledges help minority boys and girls abstain from sex.
- Minority parents can persuade their daughters not to begin to have sex. Yet frequent religious involvement, high self-esteem and a parent's presence in the home after school or at

dinner seem to have no significant effect on whether young people have sex. Religious involvement protects Hispanic females from attempting suicide or having sex, but it offers insignificant protection from other behaviors.

- A healthy relationship with parents reduces the risk of suicide for minority youth.
- Minority youth who are physically mature are more likely to engage in several risk behaviors, including alcohol consumption.

Although 25 risk factors were examined, problems with schoolwork are the most serious and significant for poor black teens in urban areas as well as affluent white teens in suburban areas. Dr. Robert Blum, principal investigator of the study, and his colleagues state that while resources are still needed in the inner city, targeting neighborhoods based only on race and/or income will not solve the larger public health problem.

For more information about the study, "Protecting Teens: Beyond Race, Income and Family Structure," go to <http://www.apha.org>, and see the December 2000 issue of the American Journal of Public Health. &

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Stress life-long learning.

A: Suganya Sockalingam, Ph.D., Assistant Project Director at the National Center for Cultural Competence at the Georgetown University Medical Center, said:

"The development of culturally competent skills is dependent on the professional's current level of understanding regarding the definitions and principles of cultural competence, and strategies for acquiring cultural competence in healthcare delivery. The acquisition of cultural competence is a dynamic and evolutionary process. Experienced professionals both recognize the need and plan for continuous skill development activities."

Brian Gibbs added:

"It is important for us to understand that cultural competency is an ever-evolving, dynamic experience. To improve skills in cultural competency, we must appreciate that these are skills which evolve throughout life and involve a certain vigilance and awareness. No one person is so advanced that he is free of biases."

For more information about cultural competence and HIV/AIDS, see Resources on page 15, or contact the OMH Resource Center at 1-800-444-6472. &

Summer Internships



Several hospitals and other health organizations in the Detroit-Ann Arbor, Michigan, area have agreed to provide paid summer internships in health administration and policy to qualified undergraduate minority students. These internships are part of the University of Michigan's School of Public Health Summer Enrichment Program in Health Services Administration.

This internship program provides students with a chance to earn money during the summer and with a way to learn more about the kind of work that professional administrators and policy makers in the health care field perform. The ultimate goal is to increase minority participation in a career area in which minorities have been underrepresented. The program, which was begun by the Department of Public Health in 1986, has enrolled more than 230 students in the last 15 years. Students who are entering their junior or senior year in the fall of 2001 may apply. The 2001 program will run from June 13, 2001, through August 9, 2001. The application deadline is March 5, 2001.

For an application and more information, call Carmen Harrison at 734-936-3296, or send an e-mail to um_sep@umich.edu. An application can be completed online at <http://www.sph.umich.edu/hmp/sep/application.htm> or can be downloaded at <http://www.sph.umich.edu/hmp/sep/appform.pdf>.&

Funds Available for Faith-Based Caregiver Programs

Grant applications are now available to expand Faith in Action, a national interfaith volunteer caregiver program of The Robert Wood Johnson Foundation.

The \$35,000 start-up grants will be

awarded for 30-month periods to help communities organize coalitions for volunteer caregiving to better the lives of people with long-term health needs.

In addition Faith in Action will offer the new coalitions significant support and advice on how to develop successful, sustainable caregiving programs that can serve their communities for many years.

Faith organizations, community-based volunteer organizations and social or health services provider agencies desiring to create a Faith in Action program are encouraged to apply.

The deadlines for application are February 1, June 1, and October 1, 2001.

For more information on the Faith in Action program, call toll-free at 877-324-8411 or visit the website at <http://www.interfaithcare.org>, or email grants@interfaithcare.org.&

Complementary and Alternative Medical Education

The National Institutes of Health's National Center for Complementary and Alternative Medicine (NCCAM) offers Education Project Grants that support the development, refinement, and expansion of innovative educational approaches for incorporating complementary and alternative medicine into the medical, dental, nursing, and allied health professional schools; into residency training programs; and into continuing education courses.

NCCAM's Complementary and Alternative Medicine (CAM) Clinical Research Curriculum award is intended to stimulate high-quality, multidisciplinary training as part of the career development of CAM clinical investigators. NCCAM also funds individual fellowships, investigator training grants and career development awards to encourage traditional and CAM practitioners to conduct CAM research.

For more information regarding NCCAM's funding opportunities, call 888-644-6226, or visit the investigator's page at <http://nccam.nih.gov/nccam/fi>.&

MAC Cosmetics Supports HIV/AIDS Programs

In 1994, MAC Cosmetics established the MAC AIDS Fund to support local organizations that work to improve the quality of life for men, women, and children living with HIV and AIDS. MAC's Viva Glam Lipstick Program provides HIV/AIDS organizations with funds for education, prevention, emergency, and support services. Its Kids Helping Kids Program specifically benefits pediatric HIV/AIDS organizations.

The Directors of the MAC AIDS Fund review proposals on a quarterly basis. Top priority is given to organizations that provide direct services such as meal delivery, grocery purchase, emergency financial assistance, and homecare support services.

For more information, call 1-800-611-1613, extension 2518, or send an e-mail to macaidsfund@maccosmetics.com. Information is also available at <http://www.macaidsfund.org/>. You may also write to David Hopley, Program Director, The MAC AIDS Fund, 360 Adelaide Street West, Suite 301, Toronto, ON, M5V 1R7.&

OMHRC Updates Funding Guide

Designed to better assist grant seekers in their search for funding sources for health-related activities, the guide contains information that individuals and organizations can use to begin their research on funding opportunities.

It also includes resources to enhance one's knowledge of public funding, private funding, and the basics of getting started in the search for funding sources.

Call 1-800-444-6472 to order your free copy, publication number 081. The OMH Resource Center also has information specialists available to perform customized funding database searches for you.

Organizations

Complementary and Alternative Medicine

Bastyr University AIDS Research Center

<http://www.bastyr.edu/research>

National Center for Alternative and Complementary Medicine

<http://www.nccam.nih.gov>

New Mexico AIDS Education and Training Center

<http://www.aidsinfonet.org/>

Northwest Institute of Acupuncture and Oriental Medicine

<http://www.niaom.edu>

Cultural Competence

American Public Health Association

<http://www.apha.org>

Bureau of Primary Health Care

<http://www.bphc.hrsa.gov>

Cross Cultural Health Care Program

<http://www.xculture.org>

National Center for Cultural Competence

<http://www.dml.georgetown.edu/depts/pediatrics/gucdc>

Resources for Cross Cultural Health Care

<http://www.diversityrx.org>

Faith-Based Organizations

Balm in Gilead, Inc.

<http://www.balmingilead.org>

Congress of National Black Churches

<http://www.cnbc.org>

National Alliance for Hispanic Health (formerly National Coalition of Hispanic Health and Human Services)

<http://www.hispanichealth.org/>

National Catholic AIDS Network

<http://www.ncan.org>

Mental Health

American Association of Pastoral Counselors

<http://www.aapc.org>

American Psychiatric Association

<http://www.psych.org>

National Institute of Mental Health

<http://www.nimh.nih.gov>

National Mental Health Consumer Self-Help Clearinghouse

<http://www.mhselfhelp.org>

Publications

Complementary and Alternative Medicine

AIDS and HIV: Alternative Medicine Resources

<http://www.pitt.edu/~cbw/hiv.html>

Alternative Medicine Review:

A Journal of Clinical Therapeutics

<http://www.thorne.com/altmedrev>

Beta (Bulletin of Experimental Treatments for AIDS)

<http://library.jri.org/library/news/beta/issues.html>

Sensible Guide to Using Complementary Therapies for HIV

<http://www3.sympatico.ca/devan.nambiar>

Cultural Competence

Cultural Competence Compendium

<http://www.ama-assn.org>

Culture and Diversity

<http://www.amsa.org>

Developing Cultural Competence in Asian-American and Pacific Islander Communities: Opportunities in Primary Health Care and Substance Abuse Prevention

<http://www.ask.hrsa.gov/minority.cfm?content=minority>

Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities

<http://www.kff.org>

Mental Health

A Consumer's Guide to Mental Health Services

<http://www.mentalhealth.org/publications/allpubs/cmh94-5001/index.htm>

AIDS Education and Prevention: An Interdisciplinary Journal

<http://www.guilford.com/>

The Insider's Guide to Mental Health Resources Online 2000 Edition

<http://www.insidemh.com/>

For more information on

cultural competence,
faith-based organizations,
complementary and alternative medicine,
or mental health,

contact the Office of Minority Health Resource Center at
1-800-444-6472 or www.omhrc.gov

DEPARTMENT OF
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HIV Impact

Upcoming Conferences

February

17-19: Ryan White National Youth Conference on HIV and AIDS. To be held in Denver, CO. Sponsored by National Association of People of AIDS. Contact: 202-898-0414, ext. 126. Website: <http://www.rwnyc.org/>

23: Lessons for AIDS Pathogenesis and Vaccine Design from Animal Models. To be held in Bethesda, MD. Sponsored by the National Institute for Allergies and Infectious Diseases. Contact: 301-496-1921.

March

1-4: Advances in Pain Management from Research to Practice: 11th ASPMN Annual Meeting. Sponsored by the American Society of Pain Management Nurses (ASPMN). Contact: 850-473-0233 or 888-342-7766.

4-10: The Black Church Week of Prayer for the Healing of AIDS. To be held at churches across the U.S. Sponsored by the Balm in Gilead. Contact: 212-730-7381; Website: <http://www.balmingilead.org>.

12-14: Overview of Adult HIV Care for Health Professionals. To be held in Atlanta, Georgia. Sponsored by the Southeast AIDS Training and Education Center. Contact: 404-727-2938.

16-18: 2001 Community Planning Leadership Summit for HIV Prevention: Change the Course or the Epidemic. To be held in Houston, TX. Sponsored by the Academy for Educational Development, Centers for Disease Control and Prevention, National Alliance of State and Territorial AIDS Directors, and National Minority AIDS Council. Contact: 202-483-6622.

23-25: 13th National HIV/AIDS Update Conference. To be held in San Francisco, CA. Sponsored by the American Foundation for AIDS Research (amfAR). Contact: 514-874-1998. Website: <http://www.nauc.org>

24-25: Operation: Survive! To be held in Atlanta, Georgia. Sponsored by the AIDS Survival Project. Contact: 404-874-7926.

April

23-25: 4th Annual Conference on Vaccine Research. To be held in Arlington, VA. Sponsored by the National Foundation for Infectious Diseases. Contact: 301-656-0003, ext. 19.

30-May 2: Deaf Community HIV/STD Prevention Conference. Sponsored by the Communication Service for the Deaf. Contact: 651-487-8871.