TRANSCRIPT OF PROCEEDINGS

NATIONAL COMMISSION ON

ACQUIRED IMMUNE DEFICIENCY SYNDROME

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Pages 1 thru 205
Volume 2

San Francisco, California
May 17, 1991

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3 **NATIONAL COMMISSION ON AIDS**
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6 **HEARINGS**
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11 VOLUME II
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16 San Francisco Hilton Hotel
333 O'Farrell Street
17 San Francisco, California

18 Friday, May 17, 1991
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24 REPORTER: FRANCES L. RHUDY
Jim Higgins and Associates
25 San Francisco, California

1 **NATIONAL COMMISSION ON AIDS**
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3 HEARINGS
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5 FRIDAY, MAY 17, 1991
6
7 VOLUME II

8 The hearing was convened, pursuant to
9 notice, at 8:30 a.m., in Plaza Room A, San Francisco
10 Hilton Hotel, 333 O'Farrell Street, San Francisco,
11 California, JUNE E. OSBORN, M. D., Chairman, presiding.

12 MEMBERS PRESENT:

13 JAMES R. ALLEN
14 SCOTT ALLEN
15 THOMAS BRANDT
16 MAUREEN BYRNES
17 HARLON L. DALTON, ESQ.
18 EUNICE DIAZ, M.S., M.P.H.
19 DONALD S. GOLDMAN, ESQ.
20 LARRY KESSLER
21 CHARLES KONIGSBERG, M.D., M.P.H.
22 BELINDA MASON
23 IRWIN PERNICK
24 MICHAEL PETERSON
25 PATRICIA SOSA

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1 P R O C E E D I N G S

2 8:50 a.m.

3

4

5 DR. OSBORN: Good morning. I want to
6 apologize for our delayed start. I think a number of the
7 commissioners have had trouble. Yesterday breakfast went
8 just fine and I think everybody scheduled themselves that
9 way. But I think very shortly now the remaining
10 commissioners will be here. And we very much appreciate
11 all of you being patient with us.
12 I want to limit my remarks simply to a
13 welcome. We are looking forward to hearing from you today
14 and learning from you the important messages that you have
15 for us about Asian, Asian American and Pacific Islander
16 Communities. In order to start us off Paul Kawata has
17 agreed to make some opening remarks. Paul, welcome.
18 MR. KAWATA: On behalf of America's model
19 minorities I want to thank the Commission for taking the
20 opportunity for meeting with us. We want to acknowledge
21 the critical contribution that you can make in the fight
22 against AIDS for Asian Pacific Islanders.
23 My name is Paul Akio Kawata. I am a third
24 generation Japanese American. That means I am a sansei.
25 I am the grandson of immigrants. My family came to the

1 United States in the early 1900s.

2 My mother was a housegirl for the Canon
3 Towel family in Beverly Hills. My father was an orphan.
4 They lived the typical life of immigrant children. They
5 were undereducated. They were poor. But they had a
6 dream.

7 Unfortunately, on May 3, 1942, Gen. J. L.
8 DeWitt signed an executive order for the evacuation of
9 Japanese immigrants and American citizens of Japanese
10 descent.

11 To be able to effectively describe the
12 forced migration of my parents in less than 10 minutes
13 would be impossible. And one thing that I always remember
14 to all of us who do HIV related work who laugh about
15 quarantine is to remember that it happened to my parents
16 in this decade.

17 The other part of my life is that I am a gay
18 man. And for me to choose between being an Asian Pacific
19 Islander and a gay man is impossible. The two factors are
20 inextricably intertwined in who I am as a human being.

21 However, it is important to note that within
22 the gay community I am often referred to as rice. The
23 bars that I attend are called rice bars and that the men
24 who love me are called rice queen. I cannot begin to give
25 you the words of what it means to be reduced to a food

1 group.

2 We are here before you as a group of Asian

3 Pacific Islanders. I think it is important to note as you

4 look around this table that we are not a monolithic

5 community.

6 The word Asian Pacific Islander is a

7 convenient term that lumps a group of diverse people

8 together. In America we are called minorities. But it is

9 important to note that in the world there are more of us

10 than there are of you.

11 Sometimes we get lumped because of the color

12 of our skin or the shape of our eyes. But we represent

13 over 32 different major dialects, many parts of the

14 country, many parts of the world with a diverse culture,

15 perspective and values.

16 We come together as a group of people

17 sharing with you some of our culture and some of our

18 perspectives recognizing that it will never be a complete

19 snapshot or a complete picture.

20 As model minorities we get to be the good

21 colored folk. And what the good colored folk usually

22 means is that we don't misbehave. Well, maybe we may

23 misbehave just a little bit today. Okay?

24 And part of talking about misbehaving and

25 talking about being a model minority is that we get to

1 present a series of recommendations to you. I know that
2 several of you received in the mail a series of 11
3 recommendations that were developed by people.
4 And since I was not involved in the
5 development process I can say to you that they are great
6 recommendations. And I strongly encourage the Commission
7 to review and consider them as they put together final
8 reports.
9 I also know the political reality of trying
10 to put forth 11 recommendations. So, what I would like to
11 do is highlight three of the critical ones from my
12 perspective and in discussions that I have had with
13 several of my counterparts here at the table.
14 Recommendation No. 1, the Center for Disease
15 Control, state and local health departments revise their
16 surveillance and reporting practices to provide data
17 regarding HIV and AIDS according to Asian and Pacific
18 Islander ethnicity, mode of transmission, age, gender and
19 year of immigration.
20 The reason that this is critical was up
21 until recently according to the CDC we were classified as
22 other. For the first time we have the mode of being other
23 than other.
24 But the truth about it is that the umbrella
25 of Asian Pacific Islander does not effectively represent

1 who we are as diverse communities. And your support in
2 working with CDC to find that specific recommendation will
3 be critical to our prevention and educational effort.
4 Recommendation No. 3, that federal, state
5 and local governments funding of HIV prevention and
6 education targeted for Asian and Pacific Islander
7 communities be increased and that specific requests for
8 proposals, grants and contract for community based
9 organizations in Asian and Pacific Islander communities.
10 In strictly percentage terms Asian Pacific
11 Islanders represent the largest increase of new HIV
12 related infections. What that means is that the primary
13 prevention agenda is still a critical component of who we
14 are as a community. And your support in helping us to
15 further our primary prevention agenda is critical to our
16 saving our people.
17 And, finally, recommendation No. 8, that HIV
18 serum positive status be eliminated as a basis for
19 exclusion and mandatory HIV testing to be ended for
20 immigrants and refugees under the federal immigration law.
21 I want to applaud the Commission's early
22 stance in taking a position on this. I am sure that you
23 are more than aware that because of your position we were
24 able to shift the way the government looked at this
25 particular provision.

1 But I want to caution you not to compromise
2 travel for immigration. It is very, very easy for us to
3 say, well, we got travel so we can forget about
4 immigration. We cannot let that happen.
5 We also cannot let happen the Justice
6 Department to decide good public health policy. And I
7 know that you know that. And I know that you are
8 supportive. And so, I just want to reiterate your
9 commitment. I want to ask you to go on and follow the
10 distance on this particular recommendation.
11 We are a group of diverse people coming to
12 you today. At some level I feel very inadequate being
13 here among these people. I am honored to be here because
14 these are the people who are working on the front lines
15 who are making a difference every day in the trenches.
16 Theirs is the difference that is going to save the lives.
17 I salute them and their courage. And on behalf of
18 Japanese Americans I say alti gato gomaise.
19 DR. OSBORN: Thank you, Paul. A very moving
20 and succinct opening. The first panel -- Gen Iinuma,
21 Tessie Guillermo and Suki Ports -- will in sequence give
22 an introduction and historical perspective. And I invite
23 you to go, I guess, in that order.
24 //
25 //

1 INTRODUCTION: HISTORICAL PERSPECTIVE

2 Gen Iinuma
Tessie Guillermo
3 Suki Ports

4 MR. IINUMA: Good morning. Aloha kakahiaka.
5 Greetings from Hawaii. I am going to sit back a little
6 bit. This is a little too formal for me. For those of
7 you who don't know Hawaii is in the middle of the Pacific
8 and oftentimes is recognized as a vacation resort.
9 Let me give you a little tour of the
10 islands. Hawaii is I would say 2500 miles away from the
11 West Coast, 5000 miles away from decision making in
12 Washington, D. C., and usually not a part of the decision
13 making process nationally in terms of API issues.
14 Hawaii is eight islands; seven of which are
15 inhabited by a little more than one million people. We
16 come from a very diverse background -- mostly immigrants
17 -- mostly contract workers.
18 I am the third generation -- like Paul. I
19 am a sansei, an American of Japanese ancestry. I come
20 here as a representative for people who don't have a
21 voice. As you look around this table, as I look at you, I
22 don't see any representation.
23 Someone who looks like me -- I don't see
24 representation from the people that I work and live and
25 play and have grown up with. Pacific Islanders are not

1 visible. In fact, Pacific Islanders for the most part are
2 invisible.
3 As I look at all of us here today I see that
4 we are very multicultural and diverse. And it is hard for
5 me to not be moved by the enormous weight upon my
6 shoulders to be able to try to articulate from the
7 Hawaiian perspective how much a part we are of this
8 movement of Asian and Pacific Islanders.
9 The community, like I say, is very diverse.
10 Let me just give you a breakdown of ethnicity. Twenty-
11 three percent are Japanese. Eleven point three percent
12 are Filipino. Four point eight percent are Chinese. One
13 point one percent are Korean. Point six percent are
14 Samoans. Hawaiian people are one percent.
15 As you look at that it says that -- well,
16 let me give you a little more. Black Americans are 2
17 percent. Puerto Ricans are 0.3 percent. We have a mixed
18 population that comes somewhere around 30 percent.
19 Nineteen point one percent are Hawaiian.
20 And what that tells you is that 76.6 percent
21 of our people are people of color. Sixty-two percent are
22 Asian and Pacific Islanders. And if we include that mixed
23 population, that Asian and Pacific Islander community may
24 be as large as 74 percent of our population. By
25 population percentage we have the largest Asian and

1 Pacific Islander population in all the states.
2 Hawaii has been called the melting pot of
3 the Pacific. And you can see why. What these figures
4 don't illustrate is that we have a growing Indochinese
5 population. We have a Hispanic population coming to the
6 Islands.
7 It is very telling that we have other things
8 coming to the Islands too. Infectious disease is already
9 there. The statistics are also very telling too. It
10 shows that Caucasians are the minority in our community.
11 And yet, we are oftentimes used -- use a bigger minority.
12 Minority in that sense however -- or a
13 majority for us in terms of population base -- doesn't
14 really mean that we have the majority in decision making
15 or ability to control our own destiny. And our lack of
16 resources in many ways is an indication of that.
17 Hawaii has had a history and a legacy of
18 what we consider to be -- and many people consider to be,
19 especially the Hawaiian people -- colonization. As
20 started in the 1800s with the bringing of Capt. Cook. And
21 what he brought was not only his sailors but also
22 infectious disease that nearly wiped out the population of
23 Hawaii. It had a population very close to a million
24 people. And in 1875 it went down to as low as 50,000
25 people.

1 But I don't want to leave you with all these
2 statistics and numbers. I don't think that is the issue.
3 The issue for Hawaii is that HIV is there and we have a
4 real problem with the particular disease that has very
5 much similarities to other diseases that Hawaii has faced
6 in the past.
7 Some of the issues that we have are
8 infrastructure or the lack of it. I will give you an
9 example. On the neighbor islands where 20 percent of our
10 population resides there are no public transportation
11 systems. There are no detox facilities. We have one
12 methadone treatment facility in the entire state. And it
13 is located on Oahu.
14 And what that means is that if a person is
15 seeking some kind of specialized health care they will all
16 have to travel to Oahu for that or even to the mainland.
17 And what that means is that is extremely -- at a lot of
18 cost -- at very high cost and being away from loved ones
19 and their support systems in a very strange place -- an
20 unfamiliar place.
21 Lack of resources in terms of materials. I
22 can't even speak to it. It is almost appalling when you
23 think about it. That in Hawaii with this large Asian
24 population and large Pacific Islander population there is
25 a very noticeable lack of resources in terms of bilingual

1 and bicultural that had been developed there.

2 Other people, other states look to us for

3 these particular resources and we are not able to produce

4 them. And it may be that as we look at the infrastructure

5 or the structure that is set up in terms of the service

6 providers it is very telling.

7 Most of the HIV service provision is done by

8 people other than Asian and Pacific Islanders. Primarily

9 Caucasian. Very few Asian or Pacific Islanders sit on

10 boards of directors, advisory groups, are in the

11 leadership positions. To be able to outreach to

12 individuals who are HIV infected and who have a local

13 background.

14 I would like to leave you with a few

15 thoughts. And that is that there is a real need for

16 Hawaii to be a part of planning. We need to be a part of

17 our destiny and to be able to have a voice at the national

18 level.

19 We would like to be not thought of as a

20 vacation destination, only for play or beautiful beaches.

21 But think of it as a potential reservoir for disease. As

22 I said earlier, I can't speak for my counterparts in

23 Hawaii. The leis that I wear are a reminder for me that

24 there are so many people there depending on me to be their

25 voice.

1 We are in the middle of the Pacific. Our
2 counterparts -- our neighbor island communities that are
3 part of the Pacific Ocean that span thousands and
4 thousands of miles and islands look to us for help, look
5 to you for help.
6 I trust that these kinds of situations where
7 we are able to dialog with you on a personal basis would
8 be helpful. I hope that you can hear us. You can see us.
9 You will be able to do something for us.
10 When you look at me please look at me not
11 only as an American of Japanese ancestry sitting here but
12 look at me as a multicultural person trying to be the
13 voice of a number of different cultures in Hawaii. Thank
14 you very much.
15 DR. OSBORN: Thank you. Tessie?
16 MS. GUILLERMO: Good morning. My name is
17 Tessie Guillermo. I am the executive director of the
18 Asian American Health Forum which is based here in San
19 Francisco. We are a national organization focused on
20 health status improvements for the Asian Pacific Islander
21 community in the United States.
22 My responsibility here today is to set the
23 general stage or give an overall perspective for the
24 following presentations and the discussions that you will
25 be having subsequent to my presentation.

1 Paul referred to us as the model minority.
2 And I am sure you are all very familiar now with that
3 myth. I am going to talk a little bit about our model of
4 health for Asian Pacific Islanders as a model of health.
5 There is general, I guess, misunderstanding
6 about that. Some of the things that we often hear about
7 Asian Pacific Islanders is that we all live to be very
8 old, that we don't get cancer, that we somehow magically
9 overcome hypertension and its problems, that we are immune
10 from AIDS and, in short, live happy, healthy, productive
11 lives.
12 There are some elements of truth in that
13 myth. We do have longer life expectancy. We do have in
14 some groups lower infant mortality than the general
15 population. And we have the highest minority
16 representation in medical schools.
17 That all sounds very good. But there is
18 something wrong with this picture obviously. Their
19 aggregation of data under the rubric of Asian Pacific
20 Islander masks a number of things. The paucity of data
21 that leads to these conclusions masks a number of things.
22 Proportional sampling negates Asian and
23 Pacific Islander clustering. It negates our ethnic
24 diversity. And it is skewed towards the more established
25 groups among the Asian and Pacific Islander minority

1 group.

2 The other thing that this doesn't show is

3 that comparisons of health status are always made in terms

4 of white majority health problems. Many Asian and Pacific

5 Islander health problems are not of the same category.

6 Additionally, the perpetuation of our good

7 health status is conditional. And it doesn't take into

8 consideration our quality of life regardless of the fact

9 that we may live longer.

10 These conditions that I spoke of have maybe

11 existed in the past but currently there are changing

12 conditions. There is a changing paradigm. We are going

13 through a period of rapid and increased immigration of

14 indigents from our home countries, of pensioners from our

15 home countries.

16 The changes though however go beyond

17 demographics. They must be analyzed in context of United

18 States societal conditions. Asians have been in the past

19 more acceptable, I think, to a large majority of the

20 population here.

21 We don't misbehave -- as Paul said. At

22 least that is what most people think. However, now,

23 because of the increased immigration, the increased

24 visibility of our communities there is a rise of anti-

25 Asian sentiment and anti-Pacific Islander sentiment.

1 There is a rise of racism against our
2 communities. A lot of misunderstanding about what we are
3 doing here and why we are here. The present United States
4 societal, economic and political environment is not
5 conducive to our communities' ability to establish
6 ourselves and to improve our wellbeing.
7 So, those conditions are changing. We will
8 not be able to perpetuate our good health status,
9 perpetuate our relative economic stability in the light of
10 these conditions.
11 A little bit about our health status. We
12 don't have much information about it. So, what we have to
13 do is we have to look at socioeconomic information as a
14 surrogate for what our health status is.
15 As Paul said, we are diverse in ethnicity.
16 There are 43 different ethnic groups that are represented
17 by the Asian Pacific Islander category with a multitude of
18 languages and dialects. And we don't understand each
19 other's dialect or language even though we may come from
20 the same country.
21 We are largely immigrant. An average of 65
22 percent immigrant population amongst Asian and Pacific
23 Islanders. Largely non-English speaking. We are employed
24 primarily in service jobs -- 24 percent. But we are also
25 employed in managerial positions.

1 We are bipolar in education. The
2 differences are 25 percent and 79 percent respectively
3 have no high school education and have college education.
4 We are bipolar in economic status. We have the highest
5 percentage of people in poverty status in the United
6 States. And we also have a relative high proportion of
7 our communities that have fairly good economic status.
8 The implications of all of these statistics
9 have a lot to do with our ability to access programs and
10 services that we may need as people of color in the United
11 States -- particularly in relationship to the fact that
12 there is a lack of data, the misunderstanding that there
13 are sufficient numbers of service providers to impact our
14 population and the fact that we are diverse and have
15 language and cultural differences that impede our ability
16 to access services.
17 I have spoken about the lack of data. But
18 just to give you an example, California and Hawaii are
19 alone amongst all the states that collect data for Asian
20 Pacific Islanders and break that down into ethnicity.
21 Everybody else aggregates us as either Asian and Pacific
22 Islander or as other.
23 So, we cannot find out about what is going
24 on with our community in terms of health status if we
25 don't know that we are a separate from other, if others

1 don't know that we are Japanese, Chinese, Vietnamese,
2 Korean as opposed to Asian Pacific Islander as a group.
3 We are often told that there are more than
4 enough Asian and Pacific Islander health professionals
5 available to serve our needs. That may be true that there
6 are a very high percentage of Asians and Pacific Islanders
7 in the health professions. However, if you will look at
8 that a little bit more closely you will see that there is
9 some discrepancy there.
10 Most of the health professionals -- medical
11 doctors and so on -- that are available theoretically
12 don't serve where our populations concentrate. They are
13 geographically mostly located in the Northeastern part of
14 the United States. The majority of the population is in
15 the Western part of the United States.
16 And even if they were in the same location
17 most of these health professionals are in institutions,
18 are researchers, are non-service providers. They do not
19 provide day to day service to our communities. So, there
20 is definitely a misunderstanding in terms of our ability
21 to access care.
22 And then the major thing that impedes our
23 ability to access care is the fact that we are so diverse.
24 People often say that because they can't prove that we
25 demand care, that we utilize services then we must not

1 need services.
2 Well, you need to take into consideration
3 that maybe the reason that we don't demand services and we
4 don't utilize services is that we don't know how. If we
5 enter into a service facility and we cannot speak the
6 language that the provider is speaking, if that provider
7 is not familiar with the kinds of practices and the
8 behaviors that we encounter in our home countries, then we
9 are not going to utilize that service. And people need to
10 be aware of that.
11 These three things -- the lack of
12 information about our population, the misunderstandings
13 about the abilities of providers to service us and our
14 diversity in terms of ethnicity -- are the major things
15 that impact us in terms of health services and programs.
16 And they do relate specifically to our ability to service
17 our community in terms of HIV.
18 There are very few services that are
19 culturally relevant, culturally competent to serve the
20 diversity of our communities.
21 So, what do we do about that? There are
22 some solutions. But the solution is not necessarily to
23 force us to write proposals to go through the exercise of
24 setting quantifiable, measurable objectives because we
25 cannot necessarily do that.

1 There is something though that we can
2 suggest for you to allow us to do. Maybe not force us to
3 set those quantifiable, measurable objectives. Maybe to
4 allow us to get a better understanding of what is going on
5 in our community. Maybe to allow us to gain better access
6 to care. And maybe to get better ability to get language
7 and culturally competent services.
8 We should be able then in our communities to
9 plan together with you and inform you what we need. We
10 don't need you to tell us what we need. We would like to
11 be able to do that for ourselves.
12 How do we get there? We should be able to
13 survey, research and disseminate information on our
14 communities. We should be able to develop policy and do
15 program advocacy. We should be able to develop our
16 communities and to develop leaders within our communities.
17 And we should be able to have broad linkages to public and
18 private resources that may be able to help us better to
19 impact our community.
20 There are some recommendations that Paul has
21 referred to and that you have in your packets. And I
22 would really suggest that those things be considered
23 seriously. Thank you.
24 DR. OSBORN: Thank you very much. Suki,
25 welcome.

1 MS. PORTS: First, I would like to start
2 with a San Francisco hearing table weather report. It is
3 a rather historic tsunami time -- 25 APIs, 12 white, 1
4 Hispanic, 2 unknown and other or missing. (Japanese
5 phrase.) Loosely translated -- in other, missing,
6 unknown, or Japanese -- good morning.
7 It is a bittersweet opportunity to talk
8 before the Commission but I thank you for this
9 opportunity. With the discriminatory immigration quotas
10 lifted upon passage of the McCarron-Walter Act in 1954
11 enabling alien Asians to vote for the first time and to be
12 eligible to enjoy all rights of citizenship it was not
13 until 1962 when misogynation laws were stricken down by
14 the Supreme Court removing the last legal barrier to equal
15 citizenship -- particularly important because the laws
16 previous to that did not allow Asian men to marry non-
17 white or face imprisonment.
18 And yet, they could not go back to their
19 Asian country of origin to get a wife and still not come
20 under the quota -- which allowed in part for the tradition
21 that started of picture brides being brought to this
22 country. Whereas, the European men were allowed to go
23 back and bring their wives and that didn't count in the
24 quota for that country.
25 The recent ability of first generation Asian

1 immigrants to vote has limited the political power. With
2 no more startling an example than the East Coast with the
3 largest state with the second highest Asian and Pacific
4 Island population, New York, 693,760 is still not enough
5 to have a voting block of Asian Pacific Islanders to ever
6 elect someone of Asian or Pacific Island descent.
7 This political powerlessness has very
8 clearly impacted upon the services provided to APIs --
9 from only English school liaisons to homes where 73
10 percent of the parents and children speak their own
11 language at home to health care in a state which does not
12 for the most part even list other in stats like cause of
13 death which lists whites, blacks, Hispanics. Does that
14 mean we don't die?
15 Nor are we drug treatment clients. Nor are
16 we STD clinic clients. In any AIDS listing until October,
17 1990, when stats were published for the first time in
18 December were we there as Asian and Pacific Islanders not
19 tied with Native Americans. Previously we had all been an
20 other with no identifying or explanatory asterisk.
21 New York City has yet to separate the Native
22 Americans from other claiming confidentiality reasons
23 though APIs were separated out in January of 1991 because
24 -- in quotes -- the numbers had risen enough to warrant
25 it.

1 Whereas in New York State the excuse has
2 been the numbers were too insignificant to warrant the
3 expenditures for surveillance data, hotline language
4 capability, or materials translated in any API languages.
5 I question how one would feel as a mother or as a lover to
6 find that your partner or child was too insignificant.
7 New York State's most recent April, 1991,
8 magazine about AIDS and substance use never once mentioned
9 APIs. New York City and State are not alone. This has
10 happened up and down the East Coast.
11 And Washington which provides stats like the
12 U. S. Department of Justice has just put out a bulletin on
13 female victims of violent crime. And while many Asians
14 will not report such situations women listed are black,
15 Hispanic, or other, and white.
16 The fastest growth rate in the '80s among
17 APIs as identified by the U. S. Census Bureau -- a large
18 part due to the 1986 Immigration Act which enabled many,
19 particularly from Southwest Asia to immigrate -- a whole
20 new series of communities speaking other among the 50
21 languages other than English. In New York City, for
22 example, where there is no translation other than Spanish
23 -- and sometimes Creole.
24 From two Asian Americans, Paul Kawata and
25 me, attending the first CDC conference in 1987 to over 20

1 in 1988 and under 100 in 1989 the API community
2 participation has grown.
3 With the contrast of 1990 U. S. Census
4 3,830,850 Pacific Rim people on the West Coast with
5 political power at every level of government including
6 elected and appointed to the East Coast U. S. Census
7 figures of 1,959,049.
8 The numerous CBOs and the involvement of
9 city, county and state contrasts with the East Coast where
10 APIs are represented by a handful of advocate agencies
11 with even fewer governmental agencies assisting in any
12 comprehensive way and only a few foundations beginning to
13 recognize now.
14 In November of 1985 when I first started to
15 look at people of color stats in New York City there were
16 51 other and unknown adults and zero peeds. Now, five
17 years later, there are 360 adults and three peeds. Of
18 this total we know as of April 30, 1991, there are 187 API
19 men and 16 API women. Of the peeds we don't know yet
20 because they are still other without any identifying
21 asterisk.
22 Of national contrast the East Coast has a
23 total of 90,289 cases of CDC defined AIDS contrasting with
24 the Pacific Rim of 36,716. Almost invisible are the women
25 -- the majority of whom are statistics upon death.

1 Services being so limited from prenatal
2 counseling to pre-test counseling -- which in New York
3 City, home of the U. N., only 15 blocks from the hotline
4 -- has only Spanish, some Creole as I said before and
5 part time two dialects of Chinese. With all Asians
6 referred to her. And she must in turn tell them when they
7 have called a second time that she cannot speak anything
8 but two dialects of Chinese.
9 Last month a case so clearly pointed out the
10 lack of services. And yet, New York City has just gone
11 through the spectacle of yet another butterfly incarnation
12 emerging via the interchangeable other -- the Philippine-
13 Asian woman playing the Vietnamese woman playing sex
14 worker playing the stereotypical perk for an Asian GI, who
15 could just as easily be a businessman or a tourist.
16 But to update, Miss Saigon, the March 25th
17 picture of 7000 U. S. navy men having their first R and R
18 since Desert Storm. Where did the navy take these men?
19 To Pati, center of Thailand's sex industry, which suffered
20 economic loss of the Gulf War's effect on tourist and
21 business. And the military pleasure trips.
22 A navy spokesman said -- and I quote --
23 "We're beating the men over the head to use condoms. The
24 navy is doing all it can do in terms of information and
25 education to get the word across to protect every 18 and

1 19 year old sailor about how to protect themselves."
2 This protection against STD and AIDS
3 included videos on board, detailed briefings, condoms
4 distributed to everyone and additional condoms available
5 at the navy's beach office. The article did not mention
6 how the women on shore would be helped should they be
7 infected by some of our gross national exports.
8 Nor did the article acknowledge that the
9 usually most efficient transmission of HIV, for example,
10 is men to women, with limited women to men. The sex
11 industry women in Australia are highly educated and
12 organized. Contrasting with those of the Asian women who
13 do not speak out and rarely organize noticeably.
14 The women in the English speaking -- if you
15 will notice -- countries distribute a brochure to our navy
16 men that says -- get your ships, your bombs, your dicks
17 and AIDS and get the fuck out of here.
18 Incidentally, I didn't mention in the
19 backgrounds that I am probably the stegasaurus of the
20 sanseis. I think I am about the oldest sansei living.
21 And my parents would certainly be concerned that I would
22 be talking to a group of men and women of all different
23 ages, including some older than I am -- even though I am
24 stegasaurus of the sansei -- and to think that they had
25 suffered during World War II to put me through college to

1 talk about sex in a group like this would probably put
2 them in the grave if they hadn't already been there.
3 Issues which emerge from the East Coast are
4 no doubt the same as those on the West Coast. And yet,
5 because of a lack of political voice there is also lack of
6 awareness on the part of funders, particularly government
7 at any level, that there are many reasons to provide very
8 targeted culturally and language and class specific HIV /
9 AIDS prevention information to an area with pockets of the
10 newest immigrants of the 1980s coming from areas ripe with
11 HIV and AIDS. And it is circular.
12 Looking at WHO figures, the Philippines,
13 Thailand, India and Japan stand out as some of the places
14 where unlimited pleasures take place. Repeated again in
15 New York City or any city as Washington, Boston, corners
16 as far as New Hampshire, where women are battered and
17 silenced and teenagers striving to belong participate in
18 risky behavior -- sex, drugs and alcohol -- while non-
19 English parents are not communicated with by schools.
20 Recently some of you may remember the big
21 brouhaha about whether condoms should be distributed. It
22 totally went over the heads of Asian families who are
23 recent immigrants.
24 But now we have the great year of the budget
25 deficit. Just as Asians and Pacific Islanders have

1 organized in New York City in a group called APICHA --
2 which is a little bit of a pun on tea countries but --
3 Asian Pacific Islanders Concerned About HIV and AIDS --
4 just as that initiative is getting started we are talked
5 to about the limit of funds.
6 I would ask you that we must proceed with
7 very targeted, very specific -- as in those 11
8 recommendations -- assistance to people in our
9 communities. To do less would be a new form of genocide.
10 I must put one thing in context. In New
11 York State where we are told that the numbers are so
12 insignificant -- may I just point out that if in New York
13 State where we have 203 adults and three peeds as the
14 number that is too low to prioritize or to provide
15 services for, that would mean that actually eight states
16 of the 50 should stop all AIDS work because they have less
17 than we have.
18 And 19 of the metropolitan areas that the
19 CDC lists of over 500,000 should close shop because they
20 also have less than us.
21 DR. OSBORN: Thank you. At this point do
22 the Commissioners have some questions? We will be
23 proceeding to a panel discussion in a minute. Don
24 Goldman?
25 MR. GOLDMAN: Yes. I have a question, if I

1 may. A number of years ago the only example that I know
2 of of an instance in which our public health system has
3 ever involved itself or been involved in the disclosure of
4 anybody's HIV status occurred when I got a call from a
5 young man with hemophilia somewhere in the Midwest who
6 told me that there had been a tv show and they had talked
7 about the success of their local HIV confidential testing
8 program.
9 And that through this particular county "X"
10 thousands of people had been tested and everybody was
11 negative except for two people who were gay and two people
12 who were drug addicts and one person who was a person with
13 hemophilia.
14 That was fine except this person was the
15 only adult with hemophilia in the community. And
16 therefore simply by virtue of giving that data his
17 identity became disclosed. Well, strangely enough, he had
18 no problem but his wife got fired the next day.
19 The concern that I have is that some of you
20 have suggested that data be distributed on a basis which
21 clearly more narrowly defines the Asian Pacific Islander
22 status and ethnicity.
23 And my concern is that if there was a report
24 that in my community that there was even CDC data there
25 was a Burmese person with -- Burmese ancestry with HIV I

1 suspect that I could probably identify who it might be if
2 there were any people from Burma in my community. Isn't
3 that a concern for any of you?
4 MS. PORTS: I just might say that in New
5 York City the whole impetus for AIDS research and AIDS
6 services started with six white men. So, you know, I just
7 don't think that is a valid point.
8 MR. KAWATA: I think there are going to be
9 several responses in order to effectively look at and
10 address this question. And in order to look at what
11 happened in your particular case we have to look at the
12 time difference, I think, between when that happened and
13 1991 and 1992 and the implementation of ADA -- of the
14 impact that ADA is going to have on our community.
15 Understanding the framework of ADA I think
16 will effectively allow us to look at the question that you
17 are asking. Because ADA is in place it gives us a lot
18 more opportunities and a lot more reasons to get more
19 specific data.
20 And what I mean by that is if we are going
21 to effectively do prevention programs, number one, we have
22 got to do it in a language that is understandable to the
23 people that we are trying to reach.
24 Number two, we have got to deal with a
25 cultural sensitivity. And the truth about it is that if

1 you do something that is targeted for Chinese people, it
2 will not work for people from the Philippines. It will
3 not work for people from Japan.
4 And what we need to understand is that
5 unlike other communities because we all speak different
6 languages if we don't get good demographics of where HIV
7 is spreading and how it is spreading we are not going to
8 be able to fully understand how we need to target our
9 education, what languages those education programs need to
10 be in and how we can effectively outreach within those
11 cultures.
12 MS. DIAZ: Last year I had the opportunity
13 under a program funded by the Office of Minority Health to
14 provide some technical assistance to APICHA right here in
15 San Francisco. Is there anyone in the audience from that
16 organization? Hello.
17 I worked with Debra Lee and others looking
18 at the kind of networking that you are doing across the
19 nation in providing a number of community health centers
20 that serve Asian Pacific Islanders with AIDS information.
21 And one of the things that I suggested at
22 that time was really looking at some of the materials and
23 strategies and interventions that had been developed in
24 the mother countries in terms of being able to educate in
25 prevention and education around HIV issues so that a lot

1 of that work could be either built upon here and not
2 developed de novo -- and many times not available in many
3 of the languages that it would require to meet the needs
4 of 43 different populations that you have described this
5 morning.
6 Do you know of any federally funded or state
7 efforts that would pull together educational materials in
8 prevention and education for a massive response in the 43
9 languages that it would require to reach a large
10 population like this?
11 Because rather than to develop these all
12 anew a number of countries have some very valuable
13 material. I am thinking specifically of Thailand. I know
14 that some very good materials have been developed.
15 I also know of the Philippines where there
16 has been a lot of work put into educational material
17 development. And do you know of any programs that would
18 facilitate that use of materials prepared in the mother
19 countries that might aid rapid dissemination of
20 communication efforts to the 43 populations you have
21 described?
22 MR. IINUMA: I would like to address that
23 from the standpoint of Hawaii. And first of all, let me
24 address what you said about an organization that may be
25 nationally based.

1 In Hawaii we have eight islands. And it may
2 be that one organization may participate in that national
3 organization. But we have got hundreds of organizations
4 that don't have a voice at that level.
5 And, again, our community doesn't have an
6 opportunity to dialog at the national level with many
7 Asian and Pacific Islander communities. And one strategy
8 may be to provide us with an opportunity such as this so
9 that we can have an opportunity to speak among ourselves
10 and address some of the issues.
11 The other point is that although you may
12 have strategies developed for the mother country -- as you
13 said -- it may not be appropriate for our communities. We
14 have very specific wants and needs.
15 Those individuals or those communities that
16 reside on the mainland, for example, those same strategies
17 would not work in the islands. We have our own mechanism
18 for dissemination of information ---
19 MS. DIAZ: But then let me ask you a
20 question. Would materials developed in Spanish for a
21 Puerto Rican population both on the mainland and on the
22 island of Puerto Rico -- could they be used in Hawaii for
23 the Puerto Rican population that is Spanish speaking?
24 MR. IINUMA: I am not real certain because I
25 don't speak that. I can say that some of the kinds of --

1 for example, in Hawaii all the education strategies are
2 primarily English based, Western models.
3 We have the local kids looking at the
4 material and going -- what is this stuff, this is not us.
5 You know, what I am saying is that there are children
6 there going through the formal educational process but
7 their form of communication is pidgin English.
8 And so, even if it is proper English, they
9 will look at it and go -- oh, this is something that I
10 don't like. And they will pass it aside.
11 MS. DIAZ: Sir, you have in Hawaii the
12 Kalehe Refugee Center with an education program for
13 immigrants into Hawaii. Do you not think that materials
14 developed in the mother country in those tongues might be
15 useful to the people coming into Hawaii rather than,
16 again, being able to have to develop into so many
17 languages that that particular refugee center serves?
18 MR. IINUMA: Again, let me just say that you
19 have one center on Oahu. We have got eight islands. We
20 have got so much data. There is just one center that is
21 not able to address all the needs of all the immigrants.
22 MS. GUILLERMO: I think also what Gen is
23 saying is that materials development is one thing but it
24 is not all there is to do about prevention. What we need
25 moreso, I think, than monies to create a new brochure are

1 resources to facilitate outreach, resources to facilitate
2 linkages and resources to get those materials out to the
3 community.
4 It is not all about creating a new brochure
5 and leaving it there for somebody to pick up. So, those
6 materials may be appropriate linguistically. But in terms
7 of being able to make sure that those materials are picked
8 up and utilized appropriately you need something much more
9 comprehensive than that. And that is what we are
10 advocating. It is not just materials development in
11 particular languages.
12 DR. OSBORN: I think we are going to be
13 getting an opportunity to pursue this kind of discussion
14 -- which I think is very useful -- but I wonder if we
15 might want to proceed since the initial presentations were
16 intended as historical background. And we will be going
17 onto some of the issues that will raise this kind of
18 discussion again if we went forward.
19 And I would then ask Jane Po to moderate.
20 And I think my understanding is that you will be willing
21 to moderate fully and including perhaps introducing people
22 or having them introduce themselves so that we can enjoy
23 the discussion.
24 //
25 //

1 ROUNDTABLE DISCUSSION: IMPACT OF HIV DISEASE AMONG
2 ASIANS, ASIAN AMERICANS AND PACIFIC ISLANDERS

3 Moderator: Jane Po

4 Kiki Ching
Lei Chou
5 Billy Gill
Sharon Lim-Hing
6 Martin Hiraga

Sinh Nguyen
Robby Robison
Merina Sapolu
Paul Shimazaki
Velma Yemota

7 MS. PO: Yes. I am Jane Po from the San
8 Francisco AIDS Foundation. And I have been given the
9 challenging task of keeping watch over the Pandora's Box
10 that this Commission has opened. Politely referred to as
11 the moderator.

12 And I would also like to put it on record
13 that as moderator I am expected to come here without any
14 biases. Unfortunately, I come here with the sympathies
15 that are about to be expressed by the coming panel.

16 The rules of the game will be a brief
17 background where you should state your name and the
18 communities you serve. And also if you will please limit
19 your initial presentation to five minutes we will have 15
20 minutes worth of presentation after which about 15 minutes
21 will be open to questions from the panel.

22 We will also go according to the way your
23 names are listed on the agenda. So, can we please begin
24 with Kiki Ching?

25 MR. CHING: Hello. My name is Kiki Ching.

1 I am an HIV psychiatric social worker for San Francisco.
2 And I am stationed part of the time at Health Center One
3 where I serve as the psychiatric liaison to the HIV
4 Clinic.
5 I have also been involved with the Gay Asian
6 Pacific Alliance Committee HIV Project. I facilitated a
7 support group for gay Asian and Pacific Islander men with
8 HIV for the last 2-1/2 years and have just started working
9 with Lorelei in terms of putting together a caregivers
10 group for Asian Pacific Islanders.
11 Given the lack of time I just want to
12 attempt to quickly run through some basic themes and
13 issues that I have been thinking about. And the first
14 category has to do with family issues.
15 I think one of the most basic values in
16 Asian and Pacific Islander families is the sense of taking
17 care of your own family members when they are ill and
18 dying.
19 However, the social implications of this
20 disease has been so frightening and repugnant to people
21 that it often results in the ultimate rejection of this
22 basic value.
23 And so, what happens is that many times sons
24 and daughters, brothers and sisters go uncared for. And
25 it is quite a tragedy. Parents don't want to be exposed

1 to information. They avoid places associated with HIV
2 services.
3 They are fearful about their children being
4 given HIV information. There is the feeling that it is
5 something that foreigners are trying to shove into their
6 own communities. And they do their best to keep it out.
7 I attended a conference once for Asian
8 Pacific Islanders. And these were people from our own
9 community addressing the gay Asian Pacific Islander
10 subgroup as a vector of transmission. And there was this
11 sense that if HIV could be limited to the gay Asian
12 Pacific Islander community, that Asians and Pacific
13 Islanders would be spared.
14 The different immigration histories,
15 experiences, length of stay in the U. S., generational
16 differences also affect the ways in which people respond
17 to this crisis. And this has caused great conflicts
18 within families when people have varying degrees of
19 acculturation and attachment to the larger external
20 community.
21 There are the issues of shame, taboo against
22 talking about sexuality and death. Also, in Asian
23 families the role of the gay son is often quite -- it is
24 quite poignant in that many times families concentrate
25 their resources on the sons.

1 They have been through insults of war and
2 immigration. And they pool together their limited
3 resources and fund their sons to go to college. And in
4 return he will be successful and support the family and
5 carry the family line.
6 A son who is gay and is HIV positive feels
7 not just the pain of his own experience but he has failed
8 generations preceding him and generations to follow.
9 Families may also come around to responding
10 to the physical illness. But they still have to deal with
11 the other social issues -- their son's sexuality, for
12 instance.
13 For those who are untested it presents
14 another set of issues. Many times what I come across from
15 Asian Pacific Islanders is the belief that if you test
16 positive, it means that you have AIDS and that you are
17 going to die. Your family will reject you. And so,
18 people think why get tested and risk being abandoned by
19 your family.
20 Resources are inadequate. There is no cure.
21 What is the point of risking the loss of the only thing
22 you have for something that can never replace that
23 support.
24 One of the great tragedies of my work is
25 coming across people who have suspected for years that

1 they were HIV positive. Their ex-lovers died of AIDS.
2 They have friends who are dying.
3 And they avoided getting tested. And it
4 wasn't until they developed fullblown AIDS that they found
5 out that they were positive. And it is so sad because you
6 realize it is quite unnecessary now.
7 For immigrants it is a particular problem.
8 Their resources are even more limited. There are few
9 family members here. They are afraid of losing their
10 jobs, afraid of their legal status, afraid of
11 confidentiality. And they really can't afford to get
12 tested -- to do anything that will upset their precarious
13 balance.
14 For people who are positive finding out
15 about their HIV status is often followed by symptoms of
16 depression, suicidal ideation, isolation. They may
17 tentatively go to a health clinic, find that services are
18 defined in such a way that is quite foreign to them.
19 They don't get a sense of caring from their
20 doctors. There might be a long waiting list. They lose
21 heart and they never show up. Or they have a complaint
22 about their doctors. Asians typically don't voice them.
23 It is impolite. And what they do with their
24 dissatisfaction is that they don't follow up with
25 services. And it is something that people can't afford to

1 do.

2 For women and for hemophiliacs who have HIV
3 it is an even more significant problem in that most of the
4 services have been defined by gay men for gay men. And
5 these people are forced to fit into services that are not
6 adapted to them.

7 I remember one case -- a monolingual Chinese
8 man who got AIDS and was put in a halfway house for people
9 with AIDS. His three roommates were gay Caucasian men who
10 had no connection, no similarity with him.

11 For people who are HIV negative or gay Asian
12 Pacific Islander men there is the problem of negotiating
13 safe sex. But how do you negotiate safe sex when your
14 culture says that you shouldn't talk about these things,
15 that it is taboo.

16 Safe sex negotiation requires a kind of
17 specificity. You have to be able to say to someone what
18 you feel comfortable doing and not doing. But I think our
19 culture tells us that it is not okay to talk explicitly
20 about these things. So, people rely on implicit messages,
21 indirect innuendoes -- which don't often work. And the
22 result is that people find themselves in predicaments that
23 they don't know how to get out of.

24 Lastly, in terms of community resources, it
25 is easy, again, to forget that when we refer to Asian and

1 Pacific Islanders we are talking about quite a diverse
2 group.
3 And this category is really out of
4 convenience. And we must not forget that we have to take
5 into consideration the vast differences and advocate for
6 diverse services while recognizing that we have to work
7 with limited resources.
8 It is a problem for Asian Pacific Islanders
9 who are working in the field of HIV because we are often
10 forced to be all things to all people. And it is a real
11 dilemma in terms of defining our services and
12 prioritizing.
13 Also, what I found is that -- this is
14 something that I think is hard for a community to talk
15 about. But we are such a diverse group. And historically
16 we have not been accustomed to working with each other.
17 And there has been warfare within the different ethnic
18 cultures.
19 Just a generation ago my mother often sat
20 down with me and warned me about the dangers of
21 associating with the Japanese. That was just a generation
22 ago.
23 And so, now I find being one of a few but
24 growing Asian Pacific Islanders working in HIV that I have
25 to serve a number of people who may not look at me as one

1 of their own. I guess I will stop here.

2 MS. PO: Yes. Again, may I remind the next

3 speakers about the constraints of time. I know there is

4 merit in repetition but if some of the issues that you are

5 about to raise have already been raised, if you can just

6 move onto other things. The next person is Lei Chou.

7 MR. CHOU: Good morning. I would just first

8 like to acknowledge all the Asian Pacific Islanders around

9 the table. From my pretty limited experience dealing with

10 HIV and AIDS it has been lonely talking about API issues.

11 And it feels really good to see you here. I feel like we

12 have family.

13 And to the Commissioners, if you sense some

14 kind of resentment from us, I would like you to know that

15 it is not personal. We feel resentment because here we

16 are again explaining ourselves. And we do this -- we have

17 been doing this and we will be doing this for the rest of

18 our lives. I can't just simply be. I have to explain

19 constantly. I just would like to have that as a

20 background.

21 This roundtable says the impact of HIV

22 disease among Asians, Asian Americans and Pacific

23 Islanders. And to that I have to say I don't know. And I

24 say that because of the following.

25 Without an analysis of the structural issues

1 that we as Asian Pacific Islanders constantly have to deal
2 with you are not going to be able to understand the
3 frustration that we have.
4 And the structural issues that we are
5 dealing with are institutionalized racism. Suki has
6 basically mentioned some of the things about statistics.
7 And it starts from the CDC definition and how it is based
8 on white gay men and the diseases that white gay men get.
9 We are not white gay men. We probably get
10 different diseases. But we don't know. As AZT is
11 becoming a standardized treatment we don't know how AZT
12 works on us. As it has been pointed out by a recent VA
13 298 study in which Asian Pacific Islanders weren't even
14 participating in.
15 As far as -- and the second thing is the
16 whole issue with numbers. This HIV epidemic has been so
17 centered around numbers. I am not denying the complete
18 devastation that is being experienced out there.
19 But to that I would say are our lives worth
20 less because there are less of us here. Do we have to
21 wait until half of our population is gone to be able to
22 get noticed by the government? We are a small group of
23 people compared to the entire population of the U. S.
24 And at this point I really don't know how
25 the extent of HIV infection in our communities. And I

1 hope and pray it is not going to get worse. And I can say
2 to you that if you tell the government to give us money,
3 we will show you what we can do to save lives.
4 One issue about cultural relevancy. All I
5 have to say is that cultural relevancy is not a luxury.
6 It makes a difference between whether or not someone is
7 going to understand what you are telling them. Someone is
8 going to think that you are speaking to them.
9 It is not that you say something; we are not
10 listening. No. It is because you are not talking to us.
11 There is an article from the New York Times recently --
12 and I am sorry I don't have the dates on it. It describes
13 a pretty innovative program targeted towards sixth
14 graders.
15 It is a mobile van with a computer game.
16 And this article is called the Chinatown Journal. It
17 tells when this van went to PS 1 where 75 percent of the
18 students are Chinese. Most of them are recent immigrants.
19 And this is what happens. Many sixth
20 graders spoke Cantonese among themselves. As they
21 registered their answers by touching the appropriate box
22 on the screen some Chinese students identified themselves
23 as white rather than Asian.
24 Others clearly confused answered yes or true
25 to every question. This is what we face all the time.

1 And when it comes to HIV there is one word for that and it
2 starts with a "G".
3 I, myself, was an immigrant. I came to this
4 country 10 years. I came in the early '80s just as the
5 HIV epidemic was starting. And the spooky parallel of
6 that is in New York City Asian Pacific Islander numbers
7 have more than doubled. We grew 121 percent at the same
8 time the HIV epidemic is going. What kind of information
9 are they getting? To my knowledge, they are not getting
10 any. Thanks.
11 MS. PO: Billy Gill.
12 MS. GILL: Good morning. My name is Billy.
13 I am not a professional.
14 DR. OSBORN: If you can get quite close to
15 the microphone? It may be hard for people to hear you
16 otherwise. Thank you.
17 MS. GILL: Okay. I am not a professional.
18 I am here as a mother who lost her son last October of
19 AIDS. He was a -- oh, incidentally, I am Burmese. He was
20 a substance abuser. He was incarcerated.
21 He became ill. And evidently the prison
22 didn't know what to do with him -- about him -- or how to
23 treat him. And so, he, himself, started doing research.
24 He wrote many letters. He read many journals.
25 And the only response he got was Cara Lee

1 from the Asian Pacific Island AIDS Group. And we had been
2 trying to get him home because I wanted to take care of
3 him.
4 And it wasn't until the Asian community went
5 out and gave their full support that I could get him home.
6 Well, I got him home. And all the so-called services that
7 were out there really not out there.
8 I had a hard time finding a doctor. When we
9 did finally get a doctor he was not too kind. A lot of --
10 I felt -- discrimination. One night I called when my son
11 who had dementia taken off and he said -- why are you
12 calling me at 1:30 in the morning. I could go on and on.
13 But I just wanted you to know that there
14 really isn't that much in the way of service. If Paul
15 didn't have the family -- that is his brothers and sisters
16 and myself -- and whatever little help that the Asian
17 community could give -- and they are strapped. They are
18 really strapped. There is not much that they have.
19 But however they could help. They were the
20 ones that helped. And that is what I am trying to do now
21 -- is to help. Whenever I hear of someone who does need
22 help. I know there is very little out there. I give my
23 time to that. I am not professional in any way. That is
24 all I have to say. Thank you.
25 MS. PO: Sharon Lim-Hing.

1 MS. LIM-HING: Good morning. I am a humble
2 community activist in Boston. I am here to speak about
3 the gay, lesbian and bisexual Asian community of Boston.
4 Generally, the impact of HIV on my community has resulted
5 in a state of denial.
6 Men often admit they haven't gotten tested
7 because they are too afraid, if they admit that. This
8 state of affairs has not been helped by organizations that
9 should be out there educating.
10 Gay Asians are a particularly neglected
11 group in Massachusetts. Unacknowledged by Asian health
12 educators and ignored by gay organizations. For example,
13 in 1990 the AIDS Action Committee of Boston did a far-
14 reaching survey of sexual practices among gay and bisexual
15 men.
16 The classifications for ethnic groups went
17 as far as listing Portuguese. But Asians were lumped
18 under the rubric other. If no statistics on gay Asians
19 exist this is not because the cases do not exist. This is
20 because the statistics are not being collected and broken
21 down.
22 Women debate about lesbians chances of
23 getting infected in a vacuum of information. Statistics
24 on woman to woman transmission and safer sex education for
25 lesbians are negligible in general. But in the Asian

1 lesbian community both of these elements are now
2 nonexistent.
3 This has resulted in at least two types of
4 behavior among Asian lesbians -- blissful ignorance as
5 women hop from bed to bed or marital carefulness, which is
6 when a tiny minority of Asian lesbians take the HIV
7 antibody test in order to have unsafe sex with one partner
8 in a relationship that is meant to last a lifetime.
9 Needless to say, this monogamous relationship often turns
10 out to be one in a series.
11 And whether or not that lesbian returns to
12 have another test done before moving onto the next
13 partner is highly unlikely.
14 Other barriers to safer behavior include low
15 self-esteem related to racist stereotypes and internalized
16 racism. In order to make it with some hunk a man may
17 forego bringing up the topic of safer sex for fear of
18 blowing his chances.
19 In our women's community and gay community
20 where many subtle and overt forms of racism exist the same
21 is true for women.
22 Another barrier is homophobia. For those of
23 us in the closet hoping that one is not homosexual and
24 warding off the possibility that one may be leaves one
25 without much time or energy to consider safer sex

1 practices.

2 Therefore, in order to be effective HIV
3 prevention cannot be a single issue platform. AIDS
4 education must incorporate lessons of pride and anti-
5 homophobia. Nor is prevention enough.

6 We must be ready to provide support and
7 services for those of us who do become infected. Again,
8 the same problems of outreach exist. I want to see more
9 than what I call token or easy outreach to let gay,
10 lesbian and bisexual Asians know that services are there
11 for them -- if these services are there for them.

12 As one who has done homosexuality 101
13 workshops for the South Cove Community Health Center which
14 serves the Boston Chinatown community I can attest to the
15 extreme homophobia of health care providers as well as a
16 deepseated reluctance to talk about sex in general.

17 This is also true of other Boston Asian
18 American organizations that could be disseminating HIV
19 information. Before health educators can go out and do
20 their educating they need to educate themselves. They
21 need to do a profound overhaul of how their morality
22 affects their carrying out of their mission. And they
23 need to do all of that fast.

24 Gay Asians are not the only overlooked
25 group. I would like to convey a message from Pat Song,

1 adolescent AIDS coordinator of the AIDS office in the
2 Massachusetts Department of Public Health. She is not
3 able to make it here today.
4 But she would like to advocate for Asian
5 youth. Teens as a usual part of growth experiment with
6 drugs and experiment sexually. This means that any teen
7 that has unprotected sex is at risk.
8 Currently in the United States there is a
9 syphilis epidemic. One out of every seven teens gets a
10 sexually transmitted disease. Since 1985 in Massachusetts
11 the STD rate for teens 19 and younger has doubled. And
12 kids of color have been disproportionately affected.
13 We can use the syphilis epidemic as an
14 indicator of things to come. In Massachusetts there are
15 143,500 Asian Pacific Islanders. And a large percentage
16 of these are Southeast Asian.
17 The city of Lowell, Massachusetts, has the
18 second largest Southeast Asian population in the United
19 States. Newly arrived these immigrants benefit from no
20 health education, no health care, no services. There are
21 reports of Southeast Asians taking drugs and testing
22 positive. But they are not targeted by any educators.
23 They receive no information.
24 And the epidemic will spread because all
25 communities have sex and do drugs. Massachusetts teens

1 have a relatively high level of AIDS knowledge. However
2 -- of Boston University conducted a study which found that
3 Asian youth have the lowest knowledge of AIDS of all
4 groups -- black, Latino, white and Asian.
5 There are not enough services for Asian
6 youth who are already in trouble. Drugs, homelessness,
7 crime. There are absolutely no HIV prevention efforts for
8 Asian youth.
9 Sexuality and health educators blinded by
10 the model minorities stereotype believe that Asian youth
11 don't have sex or do drugs. As someone who was an Asian
12 youth a decade ago I can tell you that is not true.
13 We must devote more funding and attention to
14 Asian youth or we may lose our future generation. Thank
15 you.
16 MS. PO: Martin Hiraga.
17 MR. HIRAGA: Thank you. My name is Martin
18 Hiraga. And I am a recovering drug addict and a gay man
19 with arc. I am very angry at some of the questions that
20 have been asked of us.
21 And I am not going to portray the model
22 minority that has been forced upon us. I am going to tell
23 you that I am angry. I am angry because I live today in
24 isolation.
25 I live today in isolation in my recovery

1 from drug addiction and I live today in isolation in my
2 recovery from HIV disease. In Washington -- well, when I
3 first began to experience symptoms of HIV disease in 1984
4 when I had my first case of shingles that covered from the
5 bottom of my chest to the back of my head there were 19
6 people with AIDS in the state of Utah where I was living.
7 I joined the AIDS Project Utah at that time
8 because I thought it would help me and because I wanted to
9 help other people who were living with HIV disease. I
10 knew 11 of those 19 people.
11 I drove sometimes 300 miles to talk to
12 people who were Mormons and who were living in small towns
13 in Utah because they were living in isolation. I am doing
14 that again today.
15 There are 385 cases in Utah today. Mind
16 you, today in Washington, D. C., where I live, there are
17 seven cases of other. I don't know who these other are.
18 I don't know because they have labeled us as -- well, they
19 have labeled Native American. They have labeled Asians.
20 They have labeled Pacific Islanders. As something other
21 than what is real.
22 I am a real person. I am a real person
23 living with HIV. When I think about my otherness I look
24 at the problem of otherness in very personal ways. In May
25 of 1989 I was taking care of my cousin who was living in

1 New York City in the epicenter of the epidemic who had
2 arc. He died of arc. He was never able to be diagnosed
3 with AIDS. He died with a disease that is not an AIDS-
4 defined disease by the CDC.
5 But in the beginning of May I had gone to
6 take care of him. And in the process of taking care of
7 him he became very ill and fell. And I dragged him from
8 Seventh Avenue and Twenty-Fourth Street to St. Vincent's
9 Hospital.
10 I carried him on my back. He weighed all of
11 90 pounds. And I carried him because it was 5:30 Sunday
12 morning and I couldn't get a cab because I looked drunk
13 because I was sick and because he looked very ill. And
14 the cabs wouldn't pick us up.
15 So, I took him to St. Vincent's. To go up
16 to the little window in St. Vincent's Hospital and say --
17 my cousin is very, very sick, I want help. And they said
18 -- I'm sorry I don't speak your language, go to St.
19 Luke's.
20 I didn't go to St. Luke's. I stayed. I
21 stayed and I stayed until they would take him. And the
22 real reason they wouldn't take him was because they didn't
23 have enough beds but they wouldn't tell me that.
24 Another part of my otherness is in an
25 essential part of how AIDS education is done. When I was

1 living in Utah in 1984 the Mormons continued to control
2 the state government. And there was no HIV prevention
3 education provided that targeted gay men.
4 The federal information that targeted the
5 general community was stated in very vague language.
6 Don't have sex. Well, what gay man is not going to have
7 sex? Because that is how we connect with other people.
8 And today I look at Asians and HIV
9 prevention education among Asians. As was stated here, we
10 cover numerous languages. We cover numerous cultures. My
11 mother is Okinawan. My father is Japanese. I am third
12 generation.
13 My parents' parents don't speak the same
14 language and often used us to interpret for them. Even
15 though we supposedly were all the same group of people.
16 And I look at a recent review that my organization -- the
17 Indochinese Community Center of Washington, D. C. -- did
18 of 200 pieces of AIDS literature provided to us by the
19 National AIDS Information Clearing House.
20 We did a review for them. There were 200
21 pieces of information in every language represented here
22 and some that are not. And we looked at AIDS education
23 that was produced here in the United States and AIDS
24 education that was produced in other countries.
25 Of those 200 pieces of information we were

1 able to recommend only 12 pieces of information. And six
2 of those pieces of information were in English. When I
3 look at AIDS education I look at AIDS education for Asians
4 in the United States.
5 For example, when I look at Chinese
6 pamphlets I look at the front of the pamphlet. And it
7 says AIDS in Chinese characters. Well, the characters for
8 AIDS in Chinese are love, death, sickness.
9 What person is going to want to read a
10 pamphlet that says if I give charitably to another person
11 I will get sick and die? No one. Appropriate AIDS
12 education here in the United States would appropriately
13 use the English characters for AIDSs and begin to talk to
14 Chinese living in America in the language that we use here
15 in America.
16 I am a Japanese American. When I look at
17 AIDS education materials that portray -- that are
18 supposedly for Asian Americans -- and it portrays whites
19 and Hispanics and blacks and Native Americans all in the
20 same group I say that is not for me. Because I am not
21 black. I am not white. I live in a city that is 70
22 percent black, 30 percent white and who knows what else.
23 I know -- when I came here to San Francisco
24 I was amazed that I didn't know every Asian I saw on the
25 street. Because of my otherness. My otherness is my

1 problem.

2 Otherness drove me to addiction to cocaine

3 and to pills. I can't drink alcohol because I am Asian

4 and I get drunk too easily. One drink and I am drunk. I

5 didn't like that. I wanted a longlasting high -- a

6 longlasting high from the pain of always being other.

7 I lived in Salt Lake City, Utah. The

8 Mormons called me -- one Mormon said to me -- there are

9 too few of you to be a minority. I moved to Rochester,

10 New York. I founded Rochester Act Up.

11 And I never came out to people as being HIV

12 infected. Despite the fact that I had begun my recovery

13 from drug addiction in 1986 and in 1987 I began my

14 recovery from HIV disease I never came out to people as

15 being HIV infected in public. Although I was speaking

16 about HIV almost every day in the print press or on the

17 television. Because I had very few relationships with

18 other Asians and I treasured those relationships with

19 other Asians to the point where I would not destroy my

20 relationship with other Asians in order to tell the world

21 that I had HIV disease and that I wanted people to pay

22 attention to HIV disease.

23 Let me talk to you about drug treatment for

24 Asians. It doesn't exist. I spent 10 years slipping and

25 sliding and relapsing from my addictions. Ten years

1 because I would go to drug treatment facilities where I as
2 an Asian man was told -- you have to pray to god. Well,
3 excuse me, but my culture doesn't teach me to pray to god
4 or Jesus. My culture teaches me to have a relationship
5 with my ancestors, to have a relationship with my peers,
6 to have a relationship with my family.
7 My drug addiction drove me to intense,
8 longlasting shame. No one ever addressed in my drug
9 treatment facility -- no one ever addressed the fact that
10 when I went back home to live with my parents that they
11 would never talk to me about the fact that I would steal
12 $300 a day from my mother's purse to sustain my cocaine
13 addiction.
14 Or that I would -- I was caught -- when I
15 was a teenager I was caught so many times shoplifting diet
16 pills -- of all things, diet pills -- from the supermarket
17 that my father set up a bail fund for me. No one
18 addressed those issues.
19 My father did those things in silence. My
20 mother replenished her purse in silence. Not because they
21 are co-dependent but because they are Asian. Because
22 Asians don't talk about those things.
23 And Asians are just now beginning to address
24 issues that really need to be talked about. But we can't
25 address it the way white people do it because we have to

1 face our shame.
2 I am going to talk to you about one more
3 thing about my otherness. Today was the very first day
4 that I ever told a large group of Asians that I was a drug
5 addict.
6 I have never said in public other than with
7 a few people who I knew and I knew I could trust and I
8 knew I could be safe with that I have HIV disease. I
9 don't tell my best friend -- that I am in the hospital
10 because I don't want people to take care of me. I don't
11 need white people taking care of me. I don't need Asians
12 taking care of me. What I need is support.
13 What I need as a person with HIV is I need
14 to be able to access the health care system. I need to be
15 able to access the health care system in a way that I can
16 feel comfortable with.
17 When my white physician tells me -- you
18 can't go to the acupuncturist because you are in a
19 protocol and the protocol doesn't allow you to access
20 other health care systems than the ones we prescribe --
21 excuse me, I am still going to go to my acupuncturist.
22 If I were to make a recommendation about my
23 acupuncturist, my acupuncturist uses separate needles for
24 me as he does with all of his patients. He uses a
25 separate set of needles. Because that is part of the

1 Maryland state regulations.
2 But I discovered that he wasn't sterilizing
3 the needles for me between uses. And I had to explain why
4 he had to do that. And he says -- well, it is the same
5 germs.
6 And I said -- well, I had to do the HIV
7 education. I, the patient. Once again, I am having to do
8 most of the work in isolation. If I were to say something
9 about Asians and Asian doctors, I would have to say that
10 that must be -- HIV must be included as a part of testing
11 and education of acupuncturists and Asian doctors here in
12 the United States.
13 But more than that white doctors have to
14 learn about how I am going to deal with my disease. I
15 have to have white doctors I can be confident in who are
16 not going to recommend treatment that will take me back to
17 my drug addiction.
18 I have to have a medical staff that knows
19 that when I come into the emergency room and I am unable
20 to breathe -- because the two kinds of diseases that I
21 tend to catch most are pulmonary infections and skin
22 infections -- that when I go into the emergency room and I
23 can't breathe the first thing they have to do is call my
24 father.
25 That when I say person to be contacted in

1 the case of an emergency I don't mean when I have gone
2 home from the hospital on a stretcher. I mean when I am
3 there my father needs to know. My sister needs to know.
4 My family needs to know because I cherish relationship
5 with my family.
6 And white people will never understand that
7 because without our families as Asians we are nothing. We
8 are nothing. We are no one. We are only whole as a part
9 of our whole family.
10 I cannot recover from HIV in isolation. I
11 cannot recover from drug addiction in isolation. I live
12 in Washington, D. C. I know no other Asian drug addicts
13 who are in recovery. I cannot recover from any of my
14 diseases in isolation because in isolation I will die.
15 Thank you very much.
16 MS. PO: Thank you. Again, the reminder to
17 the next speakers. Sinh Nguyen.
18 MR. NGUYEN: Thank you for reminding me
19 about that. And first of all, my name is Sinh Nguyen. I
20 am community organizer for People of Color Against AIDS
21 Network in Seattle, Washington.
22 And first of all, I would like to thank the
23 Commission for including me in this discussion here. I am
24 very conscious about inclusion and exclusion because I
25 have come from the refugee community. I am Vietnamese.

1 And to be able to come to this conference
2 you have to be able to express your opinion to speak
3 English well. And I think most of the people in my
4 community don't speak English well. So, this is very
5 difficult for us to go to this kind of conference.
6 And, in fact, that I have gone quite many
7 conferences. And sometimes just me in the whole
8 conference. There is no other refugee or Southeast Asian.
9 Today I am very pleased that we have three. And I
10 acknowledge the wisdom of the Commission.
11 To talk about the impact of the Asian
12 community in Seattle, Washington, I would just like to go
13 just a little bit about the population of Seattle,
14 Washington.
15 Asian Pacific Islanders in Washington is one
16 of the largest minority groups in Washington. And Asians
17 is the largest minority concentrated in Seattle / King
18 County.
19 Talk about the impact of HIV infection and
20 AIDS in Seattle, Washington. I think I need not repeat a
21 lot of information that has been discussed here. But
22 there is one thing I would like to just because I think
23 that it is important to reiterate -- the problem of
24 marginalization. The concept of other.
25 I think just before I came to this

1 conference yesterday I did a presentation in a large group
2 of refugee service providers called Refugee Forum of King
3 County.
4 Before I did the conference I called people
5 in San Francisco for statistics that is broken down in
6 ethnic groups to convince the people in my community that
7 we do have a problem here. Vietnamese do have AIDS. I
8 know because I am in contact with some Vietnamese,
9 Cambodians. Across the board -- we do have HIV infection
10 in our community.
11 But people tend to deny that we have that
12 problem. Another problem in our communities is that when
13 you talk we tend to look at the number. We don't look at
14 the rate of infection.
15 Because the rate of infection in our
16 community is very alarming. In fact, about a year ago we
17 have 18 cases. Now, before I came to this conference we
18 have 32. So, it is almost 100 percent increase. That is
19 very alarming.
20 As compared to the Latino cases -- Latino is
21 over 65. So, we are about half. But look around the
22 state there is only two Asian persons doing outreach,
23 education, prevention to the whole state. I think that is
24 not enough.
25 The problem here is not because my agency

1 does not care about the Asian community. The problem is
2 because of the system here. We often have project. The
3 project is focused on like target iv drug user, sexual
4 partner.
5 And the priority from the black, Latino and
6 then Asian. But that is understandable then because there
7 is sometimes maybe one project is we can't have money for
8 just a quarter of an Asian. So, it is very difficult.
9 And the next project -- another quarter.
10 But it is most of the time the project is not going to
11 happen the same day. So, you can combine the three
12 project together and have an Asian worker.
13 So, we end up in having non-Asian in the
14 system. So, I think the Commission should look into
15 somehow to rectify that problem. If you talk about
16 project and then we don't have any Asian to cover the
17 whole community.
18 Basically, I have three person doing
19 outreach to the Asian Pacific communities. First of all,
20 prevention, education to those that are higher risk than
21 other people.
22 And then educate the community for support
23 for those who are HIV infected and also living with AIDS.
24 Thirdly, we have educated the system to be culturally
25 sensitive to serve the people in our community.

1 Just to illustrate this, why do we have to
2 do support? Educate people in our community to support
3 those who are HIV positive and living with AIDS. There
4 are a couple incidents.
5 There is a Vietnamese who was infected five
6 years ago. And when he discovered that he is HIV positive
7 he left the family. He left the community to a very small
8 place further south. And he became very isolated.
9 One day he called people in Oregon. Not me
10 but Oregon. And the people in Oregon didn't have anybody
11 from the Asian community. So, they called back in
12 Washington and finally got in touch with me.
13 And I gave the number to the person in
14 Oregon. And the Vietnamese called me and he is very glad
15 that he talked to me. Somehow that he can have a some
16 type of connection with the system here.
17 But he is still very isolated. So, what we
18 need here -- just like the previous, Nartin here -- we
19 talk about the support of families. Support of the family
20 is very important for living with AIDS.
21 And so far he hasn't done that. He doesn't
22 have -- I mean, he doesn't have support from the family.
23 He cannot tell that he is gay and he is infected with HIV
24 with his family, with his community. I think this is a
25 tremendous fear in him. That is why he looks miserable

1 because of this tremendous fear.

2 And one day I asked him to come to speak at

3 the training for the interpreters. And he came but at

4 that moment -- no, I cannot do it because there is some

5 people I am afraid that they will leak the information to

6 the community. So, he didn't do it. And he left.

7 And I think that is fine with me because if

8 we don't force -- as long as he is not comfortable that is

9 okay. But I think that is something we have to work on.

10 Another problem is a man who has STD came to

11 a clinic. And a white doctor asked him to take off his

12 clothes. And he -- no, no, I cannot do it. And the

13 doctor insist that -- well, you have to do it because if

14 you want to get the service you have got to do it.

15 And the man just insist that -- no, I cannot

16 do it. And finally, the outreach worker intervened that

17 -- well, you have to be culture sensitive here. And he

18 have support from other outreach workers until finally the

19 doctor back up and invite a man doctor in.

20 I think that is the type of culture

21 insensitive we having to educate the people in our system

22 -- the health care system that have to provide equal

23 access to those who don't have familiar cultures and also

24 the language problem. Well, I think that is probably I

25 want to stop here because I speak too long.

1 MS. PO: Robby Robison.
2 MR. ROBISON: My name is Robby Robison. And
3 I am from San Francisco. And I am a treatment advocate
4 with the EACH program -- which is an acronym for Early
5 Advocacy and Care for HIV.
6 This program is an early intervention
7 program that is geared toward men of color and underserved
8 populations in our communities. First of all, I want to
9 acknowledge that I am a Filipino American man. And in
10 that sense I would like to say (Good morning in Tagalog)
11 to the Commission members. As well as good morning in
12 English. Because in the Philippines we have two official
13 languages as a small part of recognizing our diversity.
14 Dr. Osborn stated that diversity is critical
15 in responding to the HIV epidemic. When I think about
16 that I think about government policy. And I know that all
17 of us here as APIs are committed. And we are here in the
18 hope that we can try to effect some positive change in
19 that policy to recognize our diversity in order for the
20 government to address -- or at least help us in addressing
21 our needs as we see them.
22 Mr. Kessler mentioned that the Commission is
23 greatly interested in some of the progressive programs
24 that we have in the gay community. And I think that I
25 want to -- the EACH program to me is one of those

1 progressive programs. Because what we are doing there is
2 that our various communities that are a consortium in that
3 program have come together to address the need as far as
4 early intervention is concerned in the progression of this
5 disease spectrum.
6 We have decided to resist further
7 fragmentation along racial and ethnic lines and the fact
8 that response from government sources has been woefully
9 inadequate for us in helping us address our own needs as
10 individual communities.
11 When I look at this report that the
12 Commission has -- the April report -- when it talks about
13 early intervention and it talks about six points here that
14 it must include.
15 We over at the EACH program include each of
16 those six points. And we recognize those as important.
17 But at the same time we would add to that the richness of
18 our cultural diversity in order to try to help reach our
19 target populations and get them to take care of their
20 medical issues.
21 When I look at my work and I look at
22 clinical trials, for instance -- NIH has a large clinical
23 trial system. And we know statistically that Asian
24 Pacific Islander men are just, you know, barely
25 represented in this system.

1 When I try to relate the clinical trials
2 process to my clients as a way of -- as another option for
3 them to get involved with their medical issues, you know,
4 they have some concerns. And I echo those concerns.
5 Because if I were to just go through the
6 initial intake process, you know, and they asked me --
7 what are you, are you black, white, or other. And I say
8 -- how am I going to relate cultural sensitivity to them
9 if even just in something as simple as the form they are
10 not even acknowledged.
11 And so, to me, that seems like such a simple
12 thing that policy could change. To at least acknowledge
13 that we are there as a group.
14 When the government collects data and puts
15 this together -- as like Tessie and Suki had brought up --
16 that data is inadequate because it does perpetuate that
17 model minority myth.
18 And that model minority myth doesn't help us
19 address our needs as individual groups within this whole
20 group. What that does, in turn, is it perpetuates other
21 myths within our communities.
22 Because then this kind of inaccurate data
23 will perpetuate myths such as HIV is a disease that is
24 just strictly limited to the white devils so you can't
25 associate with them.

1 So, this really hampers our efforts as far
2 as trying to reach our target populations and trying to
3 help them recognize that there are problems but that there
4 are resources and there are options out there for them to
5 access so that they can be helped.
6 Basically, I would just like to see the
7 government to really recognize and acknowledge our
8 diversity as different cultural groups, you know. And
9 within that especially all the different subgroups.
10 We can do the work. And this program is
11 just a small part of showing that we are out there. We
12 are involved with different individual programs. And we
13 already have these mechanisms in place.
14 We are not asking the government for
15 handouts. We just want the government to acknowledge what
16 we are doing and to ask us what we need. And then we can
17 go out and do the work and do it effectively and do it to
18 where it is culturally responsive to the needs of our
19 individual communities.
20 When I look back in history it does show
21 that when the government recognizes a problem and does
22 take responsive steps to take care of that problem it can
23 effect change.
24 Early on syphilis was recognized as a big
25 problem and the government recognized that. And it funded

1 educational prevention programs and distribution of
2 condoms to soldiers in World War II to the point where
3 syphilis had reached such low levels that they thought
4 that they actually had seen some resolution to it.
5 So, I know that that is possible. It is
6 just a matter of recognizing and acknowledging it. My
7 personal stake in this is that I am a person living with
8 HIV. And I have had a life partner taken away from me
9 because of this disease.
10 And in particular right now because
11 especially in this city Filipinos are the most affected
12 group when it comes to this disease. I just really wish
13 that you could help provide us with assistance so that I
14 can do my job and go out there and try to prevent my
15 brothers and sisters from suffering anymore with this
16 disease. Thank you.
17 MS. PO: Okay. I will ask the Commission if
18 we can get some more time because we did start late. And
19 lest you think that this is a hegemony of Asians we do
20 have a Pacific Islander, Merina Sapolu.
21 MS. SAPOLU: I would like to say talofa,
22 malo lelei -- which means when translated hello. My name
23 is Merina Sapolu. And I work for Kokuakalehe Valley
24 Organization which is a nonprofit organization in Hawaii.
25 And we are part of -- as one of you had mentioned.

1 I also am affiliated with the Tua (sp)
2 Organization -- which is the only Samoan organization
3 doing any education on HIV on the island of Oahu.
4 HIV impacts on Pacific Islanders and Asians.
5 Because I am the only Pacific Islander present today I
6 would like to change API to PIA. I hate to be thought of
7 as an afterthought. The way Pacific Islander is added to
8 Asian it makes me feel like we are an afterthought. We
9 are not heard at all.
10 Just looking around this gathering there is
11 none of us except me. There is Gen Iinuma who has been so
12 nice to speak for us. But we would like to have a voice
13 of our own to speak for ourselves.
14 When we talk about impact of HIV in the
15 Pacific Islanders -- our communities -- I don't know where
16 to start because we will talk about cultural barriers. We
17 will open up things that we do not discuss at all in our
18 communities and which make education very hard for us who
19 are trying to do education on this to our communities.
20 We are talking about sex which is a no no.
21 We do not discuss these things. And I have realized that
22 there is no culture at all that loves to talk about sex.
23 Within our culture there are a lot of subcultures which
24 make our job harder still because then when we talk to
25 these people you have to think of other issues that will

1 be arising from these things -- like church culture that
2 teach people it is a sin, it is a punishment from god,
3 that is why these people have AIDS. How do you go about
4 those?
5 There is a lack of numbers in us in
6 education. There are a lot of communities like the Tongan
7 community back home in Hawaii. And I know even here in
8 California that nobody is working on those.
9 The Samoan communities here -- I have been
10 up here for so many times in conferences, in trainings. I
11 am the only Samoan face there. Is anybody trying to reach
12 out to these communities or are we just being added so
13 that other communities could get more funds?
14 I think the issue that I would like to talk
15 about is we need to be reached too -- just as the Asians,
16 just as the blacks, just as the Hispanics. We have to
17 have a voice of our own.
18 We have to be included in decision making.
19 Make decisions with us not for us. Because a lot of times
20 if the decisions are made for us the services are not for
21 us. We would not access those services at all because
22 they are not geared to our needs. It is geared to other
23 communities' needs. And that means that we would not come
24 near those ones.
25 And we will help then in transmitting the

1 disease without even going in for any treatment at all.
2 Our population has a very high number in sexually
3 transmitted diseases -- which make us a very, very high
4 risk community.
5 And yet, a lot of us do not go to any
6 clinics or to any services that are offered because they
7 are not appropriate -- culturally appropriate for us or we
8 are looked down upon as lazy people.
9 I do not have much to talk about. I am so
10 happy for whomever has recommended me to appear in this
11 trial, in this testimony. So, the Commission can see that
12 we Pacific Islanders too are very, very at risk with HIV
13 because of the other high risk factors that are in our
14 communities.
15 One politician called us happy campers.
16 Well, I just wanted the Commission to know that these
17 happy campers have a lot of health problems. We need help
18 too.
19 It is just as we were about to approach our
20 communities then the funding thing taken away. There are
21 no fundings anymore. Or if there are any fundings, the
22 pay is so low that nobody would like to work to be an
23 educator to educate our people. So, as a last thing to
24 say, please help these happy campers. Thank you.
25 MS. PO: Paul Shimazaki.

1 MR. SHIMAZAKI: I am going to keep it short.
2 I am not going to repeat what other people said here
3 today. I am a gay man. I am living with HIV. I do
4 outreach work with Asian Pacific Islander gay bisexual
5 men. I also volunteer my time as a direct support
6 provider.
7 I make $700 a month. I can't afford to fly
8 to Washington to get in NIH drug trials. There is an
9 obvious need for local, community based trials where
10 people can enroll through clinics and through community
11 doctors and get counseling and advice in a language they
12 can understand in a culturally sensitive way.
13 I am going to say four points. The second
14 point is I am on AZT. And as everyone knows it is not a
15 perfect drug. Its effectiveness wears out over time. I
16 have been on it for a year and a half.
17 And I am not interested in more AZT studies
18 targeting its effectiveness on specific ethnic groups.
19 Those studies should have been done years ago. Data for
20 women should have been collected years ago.
21 We shouldn't waste our time enrolling people
22 in trials for a drug that may soon be superseded by newer,
23 more effective drugs with less toxicities. Unfortunately,
24 many people can't get AZT or other drugs unless they are
25 in a trial.

1 Three, we should truly provide access to
2 Asian Pacific Islanders into these newer trials for second
3 generation drugs so that ethnicity is taken into account
4 from the beginning, not added on later. I also refuse to
5 accept the category of other.
6 The fourth, and my last, point is access is
7 different from wholesale enrollment. Access means
8 availability and informed choice. People must be able to
9 weigh the risks involved in entering a clinical drug
10 trial. Thank you.
11 MS. PO: Velma Yemota.
12 MS. YEMOTA: I am with the Gay Asian Pacific
13 Alliance HIV Project. I am a volunteer caregiver. As we
14 have heard there are so many ethnic groups bunched under
15 this title of Asian Americans that I want to speak from my
16 ethnic background which is Japanese.
17 Culturally when I was growing up -- and I am
18 sure that this happens with many other Asian cultures --
19 we were told to respect our elders, respect our parents,
20 don't bring any disgrace upon your family or the Japanese
21 community.
22 And sex was also a taboo sort of subject.
23 And so, a lot of people who are gay and HIV positive have
24 a very difficult time telling their parents. I have heard
25 several say -- I just could not tell my parents, I just

1 could not, but eventually I confided in my sister. Hoping
2 that she is going to tell the parents.
3 But I just cannot -- cannot tell them that I
4 am HIV positive. And so, these people all live in
5 isolation. And as they get sick and live in this isolated
6 life they begin to want to eat ethnic food -- especially
7 if they are not well.
8 And the person that I go to see had a big
9 hospitalization where he had pneumocystis pneumonia. And
10 he said he lost a lot of weight because he couldn't eat
11 that hospital food.
12 And so, he asked one of his friends who was
13 non-Asian to go to a certain hotel and get him some
14 chicken teriyaki and tempura and all these wonderful foods
15 that he has been thinking about.
16 And he wasn't sure when he got home -- he
17 was going to have this one on the day he went home from
18 the hospital. And he said he wasn't sure that he was
19 going to be able to eat it.
20 But he was. And he decided that he really
21 had to have ethnic food. And that is one of the most
22 important things I think. When they get sick about the
23 only thing that they really enjoy is ethnic food because
24 otherwise they are just taking a lot of all kinds of
25 medication.

1 My expectation for the Japanese community is
2 that they will have a really aggressive educational
3 program for the community people so they will know what
4 AIDS is all about.
5 As Martin said, they do have pamphlets. But
6 lots of times when you read these pamphlets that are
7 written in Japanese or Chinese or whatever it is really
8 hard to comprehend.
9 And if you had people telling you, talking
10 to you, showing you things, then you begin to really
11 understand what is going on. But pamphlets alone -- I see
12 a lot of them stacked up in my church and people take
13 them. But they still, you know, really don't know just
14 what it is all about. Thank you.
15 MS. PO: We will now open the panel for
16 questions from the Commission.
17 MS. DIAZ: I would like to ask Merina. The
18 Pacific Territories -- if the federal government or any
19 other U. S. public health authority sponsors clinics or
20 programs there or AIDS services or education or a
21 component?
22 MS. SAPOLU: Not that I know of. Other than
23 we have our clinic. And then there are other community
24 based organizations in the community and the state health
25 department who has outreach workers and health educators.

1 MS. DIAZ: Specifically for AIDS education?
2 MS. SAPOLU: For AIDS education.
3 MS. DIAZ: Okay.
4 MS. SAPOLU: With the clinic that I work for
5 AIDS education is just part of it -- which is a very new
6 added component to the whole clinic. And so, it hasn't
7 been that long. I have been in AIDS education now for
8 only three years. So, that is how long we have that.
9 MS. DIAZ: How is your clinic funded?
10 MS. SAPOLU: State, CDC.
11 MS. DIAZ: CDC.
12 MS. PO: Don Goldman.
13 MR. GOLDMAN: Thank you. I have two
14 questions. I thought I heard Mr. ---
15 MR. NGUYEN: Me?
16 MR. GOLDMAN: Yes, I am sorry. Talk about
17 an incident in which someone was being treated in a
18 program and, I guess, was asked to undress in front of a
19 woman physician?
20 MR. NGUYEN: That was a -- medical clinic
21 that is funded by public money.
22 MR. GOLDMAN: My question is when does -- I
23 would like to ask any of you to address it. When does
24 cultural sensitivity become abiding by racism, sexism, or
25 homophobia? If the same person went to a physician and

1 said they didn't want to undress in front of a gay
2 physician or said they didn't want to undress in front of
3 a black physician or said they didn't want to undress in
4 front of a woman physician, at what point does abiding by
5 those kinds of concerns become itself a form of supporting
6 racism or -- itself?
7 MR. NGUYEN: Martin, do you want to make a
8 comment on that?
9 MR. HIRAGA: Yes. First, Mr. Goldman, I am
10 going to challenge you as a white man how dare you tell us
11 what racism or sexism or homophobia -- we can speak that
12 to each other because we know what racism means to us.
13 Second, when we talk about cultural
14 sensitivity the issue of gender separation among Asian
15 cultures is paramount to our relationship to each other.
16 Because Confucian philosophy tells us that there are only
17 certain relationships that can be had.
18 Undressing in front of a woman as an Asian
19 man violates a very strong boundary between the sexes.
20 The relationships between the sexes are written into our
21 lives from the very day we are born -- not unlike
22 Americans -- but if we violate a single relationship we
23 begin to unravel the relationships that we have with other
24 people in our community.
25 And, as I said earlier, we don't have our

1 communities -- if we violate rules that begin to unravel
2 our relationships with our communities, what have we?
3 Nothing.
4 MR. NGUYEN: Another problem I think is a
5 lack of understanding of the culture is much more
6 important than just -- I mean, the insistence of asking
7 the man to take off the pants I think indicates the woman
8 doctor doesn't understand the patient's culture.
9 DR. OSBORN: I think I am going to interrupt
10 the discussion here because we are coming right into
11 provision of services as the very next theme. I think we
12 have had some very rich testimony from the panelists who I
13 hope can stay with us and be part of additional
14 discussion. But perhaps at this point a break will
15 refresh our thoughts.
16 I want before we do break to express special
17 appreciation to the panelists. I know without knowing as
18 much as I should about your cultures that many of you have
19 been particularly forthcoming in a context which is
20 difficult. Some of you have shared very personal
21 feelings. And we do appreciate how hard that can be and
22 therefore very much appreciate your eagerness to help us
23 understand.
24 With that, I think I will suggest that we
25 break for 15 minutes and return for the next panel. And I

1 hope everybody will be able to continue.

2 (A brief recess was taken.)

3 DR. OSBORN: I am going to ask again the

4 understanding of the panelists that we keep within some

5 reasonable range of the time that we have given you. And

6 with apologies to Commissioners.

7 As I am sure everybody realizes, all of us

8 have full time jobs somewhere else. And so, when we go in

9 and out it isn't always to the men's or ladies' room.

10 There are some other things that are pulling on us. So, I

11 hope you will be patient with us as we have to sometimes

12 go and attend to other matters.

13 We are very pleased that you could be with

14 us and have sat through some interesting discussions so

15 far. For this next panel I will ask Fernando Chang-Muy to

16 take over and again moderate. And I very much appreciate

17 your doing so.

18 MR. CHANG-MUY: All right. Thank you, Dr.

19 Osborn.

20 ROUNDTABLE DISCUSSION: PROVISION OF SERVICES

21 Moderator: Fernando Chang-Muy

22 Wayne Antkowiak John Manzon
Jaime Geaga Nga Nguyen
23 Dean Goishi Tony Nguyen
Kerrily Kitano Joanna Omi
24 Lori Lee Dorothy Wong

25 MR. CHANG-MUY: First, we would like to say

1 thank you to the Commissioners for convening this meeting.
2 And we would like to thank the Commission staff for
3 inviting all of us.
4 You are going to hear testimony from
5 straight, gay and bisexual people. You are going to hear
6 testimony from people from different parts of North
7 America and the Pacific Islands. And you are going to
8 hear testimony from U. S. citizens, immigrants and
9 refugees.
10 The witnesses will testify about different
11 issues. And the way we conceptualized it you are going to
12 hear from people from the Pacific Islands first. They are
13 not add-ons. They are going to go first.
14 Then you are going to hear about testimony
15 from people from the East Coast. Then we will switch back
16 to the West Coast. And then you will hear specific
17 testimony about Southeast Asians, then Filipinos, and then
18 some general issues on funding.
19 And then we will wrap up with issues on
20 language and finally with issues on youth. With that,
21 Wayne, if you could begin please?
22 MR. ANTKOWIAK: Yes. My name is Wayne
23 Antkowiak. And I am the director of Communicable Disease
24 Control from Guam. There is a number of issues I would
25 like to bring up. And in five minutes it is very

1 difficult to do that. So, I will try to go through this
2 as rapidly as possible.
3 For beginners, I think it is necessary for
4 me to give a little orientation in terms of geopolitical
5 status of Guam and Micronesian Islands. Guam is a
6 territory of the United States. We are all citizens of
7 the U. S. We have a population of approximately 140,000.
8 We have no vote in congress. We have no
9 vote in the senate. We are currently seeking a
10 commonwealth status. Now, one of the first
11 recommendations I am going to make is that I think -- I am
12 very appreciative of being invited to speak. But I am
13 disappointed that my Micronesian neighbors weren't
14 invited.
15 And my Micronesian neighbors being the
16 Northern Marianas, the Commonwealth of the Northern
17 Marianas. And these folks are also citizens. The
18 Federated States of Micronesia -- which is divided into
19 four states, the states of Panape, Yeh, Kosori and Panape
20 (sp). The Republic of the Marshall Islands. And the
21 Republic of Palau -- which is still under the auspices of
22 trusteeship to the United States.
23 All of these entities receive funding from
24 the U. S. government. And all of us are very concerned
25 with HIV in our particular part of the world. It is very

1 easy to forget about us. We are on the other side of the
2 world.
3 We don't have any political power. And I
4 doubt that we ever will have any real political clout.
5 But nevertheless HIV is a problem. And I am happy to have
6 this opportunity to at least develop some awareness in
7 terms of what is happening in the Western Pacific.
8 First off, in terms of Guam, we have
9 currently eight cases of AIDS and 21 cases of folks who
10 are HIV infected. These numbers may not sound very
11 impressive to you but for us they are numbers of very
12 significant concern.
13 Most of the HIV infection -- most of the
14 cases recorded have occurred in the last year and a half.
15 Five years ago we virtually had no AIDS cases. We had no
16 HIV cases.
17 Recently we had a team of WHO folks visit
18 us. And they spent about a week with us. And we
19 developed a medium term plan and we looked at what is
20 happening with HIV in Guam.
21 And they concurred with our position. Our
22 position being that Guam currently is a low prevalence
23 jurisdiction in terms of HIV infection. But it can
24 rapidly turn into a high prevalence jurisdiction if the
25 right interventions aren't made at this time.

1 In terms of who lives in Guam. Essentially
2 45 percent of the population is made up of Chimoros (sp).
3 They are the indigenous population. Filipinos make up
4 about 20 percent of the population. Caucasians about 15
5 percent. Most of the Caucasians however are with the
6 military.
7 We have a significant Korean population. A
8 Chinese population. A Japanese population. And a
9 Vietnamese population. So, we certainly have many
10 concerns in terms of cross-cultural perspectives.
11 In terms of risk factors and what is
12 happening on the island, in terms of sexual orientation it
13 is probably fair to say that the islanders -- and we are
14 more sexually active than what you would find in the
15 states -- you find that there is no acceptance of
16 individuals who are gay. Although that is changing. But
17 not changing very quickly.
18 We have a very high rate of teenage
19 pregnancy. We have high rates of gonorrhea. We have
20 virtually no acceptance of condoms -- or very little
21 acceptance of condoms.
22 So, in terms of the future of Guam we have
23 many, many concerns. Also, one of our most significant
24 concerns is that we currently have a major immigration
25 occurring from the Federated States of Micronesia. Some

1 are in the area of 10,000 individuals this year will
2 relocate from various states of Micronesia to Guam.
3 Guam is currently undergoing an economic
4 boom. There are jobs. In other parts of Micronesia this
5 is not the case. The Micronesians -- and when I say
6 Micronesians there are many, many cultures within the
7 Micronesian culture. It is important to understand.
8 But in general the Micronesian culture in
9 terms of its sexual orientation believes that multiple sex
10 partners is something that is rather good. They have no
11 tolerance for condoms. They have little education in
12 terms of AIDS -- little understanding of AIDS.
13 I was once told a story by a Micronesian --
14 not a story but actually happened on one of the
15 Micronesian islands. A young lady had returned from the
16 states and it was rumored that she was HIV infected.
17 But that did not stop many men from having
18 sexual relations with her. And it was their opinion that
19 although she might be infected they felt it would be an
20 insult to her if they were not involved with her.
21 So, the attitudes throughout Micronesia have
22 a long ways to go. And if these attitudes are not
23 changed, the problem in Micronesia as well as Guam could
24 be very, very significant and very serious.
25 In Guam we also have an active sex industry.

1 We have over a million tourists a year at this point in
2 time. The sex industry is not as significant as you will
3 find in some parts of Southeast Asia. But nevertheless it
4 exists. And it is another problem for us.
5 I think that the message that I would like
6 to give is first off in terms of financing Guam and the
7 territories as well as the entities in Micronesia are
8 currently facing cutbacks for counseling and testing.
9 And it probably couldn't have happened at a
10 worse time. In Guam we have just begun to get our program
11 together. We have just begun to get some type of response
12 from the community. And I think we are just beginning to
13 make inroads.
14 I believe that Guam needs to stand on its
15 own. And Guam needs to make its fair share in terms of
16 the funding of its programs. But nevertheless we are
17 looking at a 25 - 30 percent cutback in our counseling and
18 testing program.
19 We are looking at 25 - 30 percent cutback in
20 terms of funds for education. And, again, we were just
21 getting things rolling and we are facing these cutbacks.
22 That is the situation in Guam.
23 I would like to talk a little about our
24 Micronesian neighbors. The Northern Marianas have
25 reported three AIDS cases and two HIV cases. The Northern

1 Marianas -- the situation is quite similar to that you
2 find in Guam.
3 They are going through an economic boom.
4 They have a significant immigration coming from both the
5 Philippines as well as from throughout Micronesia. The
6 Federated States of Micronesia have reported two cases of
7 HIV. But as I have indicated earlier they are very ripe
8 for very extensive spread of HIV if appropriate
9 interventions aren't made.
10 The Marshall Islands have reported five
11 cases of HIV. But those are all within the military
12 population. The Marshall Islands are actually hundreds of
13 atolls spread through hundreds of square miles. The fact
14 that the cases were in the military does not mean that
15 transmission did not occur with locals since obviously the
16 military socializes with the local individuals.
17 Palau which is still under the trusteeship
18 of the United States is very economically depressed. They
19 have an iv drug problem. They haven't reported any HIV at
20 this point in time. But it is only a matter of time.
21 I think, again, in quick summary, we are
22 easy to forget about. Most people aren't even cognizant
23 of the fact that the Northern Marianas are part of the
24 United States. Most people don't realize what the
25 trusteeship in terms of Micronesia is or was.

1 I think it is essential that we open up
2 lines of communication. When I got the call the other day
3 and was invited to this I was somewhat shocked. We never
4 got calls from Washington. We rarely get invited to any
5 type of forums. But I am very pleased that that occurred.
6 Nevertheless, I think you need to hear from
7 the Micronesians. I can't really speak for them. Their
8 cultures are different. Their concepts are different.
9 And their problems could be quite extensive.
10 American policy in Micronesia has at best
11 been very inconsistent. Because of American intervention
12 Micronesian culture has changed drastically and most of it
13 not for the good.
14 I think if we ignore Greater Micronesia at
15 this point in time and if a major HIV epidemic does occur
16 in that area, that would be extremely sad. Because it
17 doesn't have to occur. At least most of it doesn't have
18 to occur.
19 So, I would ask you to please not forget us.
20 Our problems are real and the people are real. And just
21 quickly I want to allude to our health systems. Guam and
22 Northern Marianas are relatively well-developed. We have
23 modern hospitals. We have physicians. Things of that
24 nature.
25 The other entities -- Palau, Marshall

1 Islands, Federated States of Micronesia -- they have
2 significant problems with primary health care. I have no
3 idea how they would handle an HIV epidemic. It would be
4 just -- just be disastrous. So, the conditions in
5 Micronesia in terms of health provisions are seriously
6 lacking. Thank you.

7 MR. CHANG-MUY: Thank you, Wayne. In order
8 to give the other people time to testify -- and more
9 importantly, Commissioners to ask questions -- I would
10 like to remind the witnesses to keep their comments to
11 five minutes.

12 Before we go on for a five minute overview
13 of the situation in Hawaii Suki asks for 30 seconds.
14 Suki?

15 MS. PORTS: I just wanted -- if I am leaving
16 while somebody is speaking, it is not out of protest in
17 what you are saying. I did promise to leave earlier. But
18 I would like to share with the Commissioners that I have
19 never in all my five years of working in this area been
20 with a group totally Asian as these testifiers are -- and
21 Pacific Islanders.

22 And never have we had as many young people
23 share with us their very personal issues. And I don't
24 know if you understand the import of this. And I must say
25 that you need to understand it because it is very rare and

1 it is an honor for all of us.

2 MR. CHANG-MUY: Thank you, Suki.

3 MS. KITANO: Aloha and good morning. My
4 name is Kerrily Kitano, presently the AIDS activities
5 coordinator for the University of Hawaii's student health
6 service. I am formerly from the San Francisco Area, both
7 working at the Asian AIDS Project and APICHA in another
8 lifetime.

9 I have been doing prevention work in Asian
10 and Pacific Islander communities for a number of years now
11 and still very concerned that the word is not getting out
12 to our people -- gay and straight and young and old and
13 all the different ethnicities and in different regions of
14 the country.

15 Part of that is our own cultural denial.
16 Part of that is a number of different things. But I think
17 what I am going to address today mostly is the "R" word --
18 racism.

19 In Hawaii -- and myself going there and
20 being a newcomer to Hawaii -- I have been there for a
21 little over a year now and actually have lived there off
22 and on since I was 10 years old.

23 But I have been there for a little over a
24 year. And I went in that community with a certain number
25 of expectations. That there is this huge Asian and

1 Pacific Islander population. That there would be
2 materials there that we could use. That there would be
3 leadership there that we could follow role models,
4 programs, et cetera.
5 And instead what I found there, I mean, was
6 the shock of a lifetime. HIV services there largely are
7 all provided by Caucasian people for Caucasian people. I
8 want to repeat the statistic that Mr. Iinuma articulated
9 earlier. We make up anywhere from between 65 to 74
10 percent of the population in that state. And yet we have
11 no services directed toward our communities.
12 One result has been the forming of a
13 coalition. The word kalakoa in Hawaii means of many
14 colors. And we have formed a coalition called the HIV
15 Kalakoa Coalition for People of Color.
16 It seems kind of ironic that we need to do
17 this. That we are considered a minority and an
18 underserved ethno-cultural group in a land where we have
19 so many of our faces.
20 The materials that I find there -- the
21 educational materials -- again, they are from the
22 mainland. They don't target Asian or Pacific Islander
23 people.
24 And if they do target Asian and Pacific
25 Islander people, it does not take into account the

1 different regional differences. That, I think, only
2 living there you can really start understanding what those
3 are.
4 In Hawaii Asian and Pacific Islanders make
5 up 20 percent of our state's AIDS cases -- which is quite
6 different from our national statistic. And yet,
7 oftentimes, the national statistic is quoted.
8 And as a result people in our communities
9 hear that and still think we have nothing to worry about.
10 And funding also reflects that.
11 I think the importance of the coalition --
12 and, again, the irony just needs to be underscored. So, I
13 will say it again. And one thing that I am going to
14 highlight -- and I am not going to talk much about all the
15 other millions of issues that are so poignant because so
16 many of my colleagues have already gone over them. And I
17 don't have that much time.
18 But I do want to talk about our clinical
19 trials project because I think this really illustrates
20 very importantly the racism with what we are trying to
21 work with in Hawaii.
22 The University of Hawaii received a grant to
23 begin an AIDS clinical trials unit. There were three
24 grants awarded. One was, I believe, in Washington, D. C.,
25 focusing on black communities. There was one with the

1 University of Puerto Rico focusing on the Hispanic
2 communities. And the University of Hawaii -- my
3 understanding -- being focused on Asian and Pacific
4 Islander people.
5 Now, the requirements for the grant stated
6 that all you had to do was have a minority institution
7 with an enrollment of 51 percent people of color to
8 qualify.
9 So, the University of Hawaii was able to
10 qualify for that given our 65 percent Asian Pacific
11 Islander population at the university. A community
12 advisory board was formed to ensure that participation and
13 access would be had by the minority communities.
14 This community advisory board started in
15 November of last year. Not one Asian or Pacific Islander
16 person sat on that board. I was invited as a member of
17 the HIV Kalakoa Coalition to sit on that board come in
18 January of this year.
19 We were allowed one representative. I sat
20 there in a room with 18 people the only Asian Pacific
21 Islander representative. There was one other black woman
22 and 16 Caucasian people.
23 Now, this ACTU is supposed to be outreaching
24 Asian and Pacific Islanders as well as other minorities.
25 And how they defined minority in this grant is basically

1 anybody who is not a white man.

2 And if you are a white man if you use iv

3 drugs, you are also considered a minority. Some of the

4 language and the definition very much works to our

5 disadvantage here.

6 We did see a copy of the grant. It uses

7 statistics for Asian and Pacific Islanders all throughout.

8 A real emphasis. This is who we want to study. And yet,

9 this is the reality. We don't have any representation.

10 We have no voice again. This is the state of Hawaii where

11 we are the majority.

12 In March -- we meet every two years. The

13 community advisory board had two people. And now, we are

14 struggling and -- copies countrywide and alerting the

15 funding agencies and trying to get assistance from the

16 federal and national community at large because we need

17 that assistance.

18 I think I will just leave with the basic

19 thing that I have learned in doing HIV prevention and

20 education work in our communities -- no matter what

21 community it has been.

22 And that is plan with us, not for us. I

23 know my colleagues have said that. I think it just bears

24 repeating -- to continue saying that. Thank you.

25 MR. CHANG-MUY: Thank you, Kerrily. For a

1 five minute perspective on what is going on in New York
2 and the East Coast Joanna Omi.
3 MS. OMI: Good morning. My name is Joanna
4 Omi. I have worked with the Mayor's Office on health
5 policy in New York City. And I am a founding member of
6 the Asian and Pacific Islander Coalition on HIV / AIDS in
7 New York.
8 The other speakers have raised so many
9 issues this morning that it is difficult for me to think
10 of a way to present an even coherent stream of thought in
11 the next few minutes. But I will try to do that.
12 I am a sansei also. I am quite surprised at
13 the number of sansei -- at the number of Japanese
14 Americans in the room. I think it reflects the number of
15 cases of diagnosed AIDS among the Japanese American
16 population within the Asian and Pacific Islander
17 communities.
18 But it is unusual for me to sit in a room
19 with this many sansei. And it feels very good. Just a
20 moment on my background because my background feeds my
21 life and creates who I am.
22 Both of my parents were interned -- well, it
23 is a little more confusing than that. Both of my --
24 members of my family on both sides were interned although
25 I am hoppa (sp) -- I am half Japanese American and half

1 Caucasian.

2 My mother, who is Caucasian, was born and

3 raised in Japan. Her father, my grandfather, was interned

4 by the Japanese in Japan. And my father, who is Japanese

5 American, born here in California, his whole family was

6 interned here in California and in other places in the

7 Western United States.

8 They were dispersed throughout the Western

9 United States during their internment. And my father was

10 drafted and fought in the 442nd in Europe in the most

11 heavily wounded and most highly decorated battalion in the

12 Second World War.

13 Growing up with that -- growing up as a

14 bicultural person in the United States I feel that I am

15 particularly marginalized and understand very deeply and

16 personally what it means to be outcast from society at

17 large and even within my own ethnicity.

18 And as I see the growing number of

19 individuals of my generation outmarrying as my parents

20 had the courage to do many years ago I feel very

21 personally the threat of continuation of my race.

22 And I understand in a very different way

23 what it means to be -- when people say genocide I

24 understand it in a number of different ways. And I feel

25 it very personally.

1 I wanted to also say that I echo Suki in her
2 -- in the respect that she feels for the people who have
3 come out in the variety of ways in this forum. You really
4 need to understand, members of the Commission -- you
5 really need to understand what it means to come out as a
6 substance abuser, as a person with AIDS or HIV illness, as
7 a gay man.
8 To be Asian and to come out in any of those
9 ways is only something that can only recently happen. So
10 many of us cannot come out about any of those issues as
11 Asians. We just cannot do it. Even though we know as
12 activists, as social service and health service providers,
13 as government individuals and people who have been in
14 public health for many, many years -- we know what it
15 means when one person provides an individual story. We
16 know how many people that helps. But as Asians we cannot
17 come out. And I want to emphasize that.
18 Fernando said I would speak about some East
19 Coast issues. So, I will get to those now.
20 MR. CHANG-MUY: One minute.
21 MS. OMI: In New York City, as in many
22 places in the country, Asians and Pacific Islanders are
23 the fastest growing ethnic population. We have grown from
24 about 3 percent of the population in New York in 1980 to
25 over 7 percent of the population in the most recent

1 census.

2 There is about 512,000 of us now. The waves

3 of immigration between the '70s and the '90s have really

4 shifted the population in New York -- as it has across the

5 country.

6 Whereas in the '70s the predominance of

7 Asians in the United States were Chinese in the '80s it

8 became Japanese. And it is now in the '90s the greatest

9 number of new immigrants are Filipinos.

10 However, in New York City Chinese and then

11 East Indians -- Asian Indians are the greatest number of

12 Asians. And that diversity and what that means for

13 immigration across the country and the different looks

14 that immigration takes on then has great implications for

15 what we do in terms of our services.

16 More than 80 percent of the Asians and

17 Pacific Islanders in New York City are foreign born. And

18 the greatest increases in the Asian populations in New

19 York have been in the outer boroughs. And by the outer

20 boroughs we mean New York City is comprised of five

21 counties or five boroughs.

22 Most of that immigration is happening

23 outside of Manhattan which has the greatest concentration

24 by far of all HIV related services.

25 In New York, again, there is an

1 overrepresentation of Filipinos among diagnosed AIDS
2 cases. And East Asian Indians are the second largest
3 number -- are affected the secondmost.
4 There has been a 20 percent increase in
5 cases among Asians and Pacific Islanders in the last year
6 alone. And a predominance of all of the cases in New York
7 among Asian and Pacific Islanders are in the first
8 generation.
9 Even so, 24 different countries of origin
10 are represented. We have over 200 cases now. And 24
11 different countries of origin are represented. Even
12 though a predominance of those cases are among men who
13 have sex with men -- which is how we collect the data in
14 New York -- every transmission category is represented and
15 every borough is represented.
16 There is also a frighteningly large --
17 especially among women -- number of cases where we don't
18 know what the mode of transmission is. Moreso than in any
19 other ethnic category we cannot collect that information
20 on transmission among Asians because we can't tell you.
21 And quickly -- if I could just have a minute
22 to tell you what all of this means in terms of our needs.
23 When you look at the signatories on the letter that is
24 before you from this group there are 44 organizations
25 represented.

1 Only three of those are from the East Coast.
2 There is a -- relative to the East Coast the West Coast
3 is better organized and has better resources. We are not
4 going to fight with our West Coast community for those
5 dollars. But we must have services on the East Coast --
6 where the second largest number of Asians in the United
7 States are located.
8 A number of us have met repeatedly with
9 different federal agencies with groups from within -- CDC
10 and we have been told repeatedly we need to collaborate --
11 interagency we need to collaborate within the federal
12 structure. How can we do that? How can you help us do
13 that?
14 We need you to collaborate as well. We have
15 to be able to have systems which are collaboratively
16 designed which help us to look not just at HIV and not
17 just at a single ethnic group but help us to develop the
18 organizational infrastructure so that we will be able to
19 fight through this epidemic as well as all the other
20 multitudes of epidemics and issues that will arise in our
21 communities.
22 We need to be able to come together. We are
23 an international community. We need to be able to come
24 together at least nationally if not internationally
25 repeatedly so that we can share ideas.

1 As you were saying, we need to be able to
2 take the best of what we have learned in other
3 communities. And the only way that we can do that when we
4 are as diverse and as spread throughout the country as we
5 are is when we can come together and talk in the same
6 room.
7 We need to -- Billy Gill talked about not
8 being able to find services in San Francisco. San
9 Francisco is the model for HIV services. And Billy Gill
10 was not able to find services and was faced with horrific
11 discrimination in San Francisco, the most international of
12 all cities. What does that mean for the rest of us?
13 There is a critical mass of funding. But
14 the most difficult issue that we face is that we have a
15 very diverse community. And we know that we need dollars
16 in each of those ethnic groups across all of the
17 transmission categories and across all of the geographic
18 areas that are so hard hit by the epidemic.
19 There is a critical mass of funding though
20 that you need in each of those areas in order for there to
21 be any outcome that is measurable. And I am urging that
22 funding be adequate to provide for that critical mass
23 rather than in an effort to target Asian and Pacific
24 communities the dollars are spread so thin that nothing
25 is able to come of it.

1 And finally, I would just also emphasize
2 that particularly for Asian and Pacific Islander
3 communities we very much need to be able to define our own
4 models and to define success ourselves.
5 There is a very successful Alcoholics
6 Anonymous program in the Marshall Islands that has adapted
7 that model to the local needs. And part of that
8 adaptation has meant that for those individuals who are
9 participating in the program abstinence is not a lifelong
10 endeavor. Not drinking for that day is sufficient.
11 And individuals in that program are not
12 looked down upon should they think -- I may drink
13 tomorrow, I may go to an event and drink, I may drink at
14 another point in time but I am not drinking right now.
15 And that is success in that model.
16 Those types of adaptations are critical for
17 the success of any types of programs in our communities.
18 And just in closure I would like to say that in New York
19 with the Asian and Pacific Islander Coalition on HIV /
20 AIDS we have a very strong sense of urgency about the need
21 to be more inclusive.
22 And it makes me wonder how all of us -- I am
23 not sure how I was brought to this table, what I was
24 supposed to be representing as I came here. But for all
25 of us the need to recognize the incredible diversity of

1 our communities and to have that diversity recognized by
2 government entities and by funding entities will, I think,
3 spell the success or the failure of all of our efforts in
4 the future. Thank you.
5 MR. CHANG-MUY: Thank you. Shifting back to
6 the West Coast to testify is Lori.
7 MS. LEE: Yes. Thank you. I would like to
8 welcome all the Commissioners who are coming from out of
9 town and also the other guests from out of San Francisco
10 to San Francisco this morning for the hearings.
11 My name is Lori Lee. I am a fourth
12 generation Korean born and raised in Honolulu, Hawaii.
13 And currently I am the direct support coordinator of the
14 Gappa Community HIV Project here in San Francisco. Gappa
15 Community HIV Project is also known as GCHP.
16 This program offers emotional support,
17 practical support and advocacy targeted to Asians and
18 Pacific Islanders families and their partners regardless
19 of ethnicity, gender, sexual orientation to assist them
20 with their problems dealing with HIV. I would also like
21 to add the program serves a variety of clients of mixed
22 heritage too.
23 I think I was really invited here to speak
24 mostly about this topic -- the direct support program
25 model -- which to my understanding is the only program of

1 this kind in the United States at this time.

2 But before I give some observations about

3 this I would like to raise a point about this hearing in

4 general. The other day I was speaking to Tom Kim who is

5 the executive director of the Korean Community Service

6 Center where I have been very fortunate to be able to do

7 some AIDS related work in education, advocacy and

8 referrals.

9 And we both noted that I am the only Korean

10 in this hearing. And thinking about it, you know, I think

11 we came to an agreement that this lack of Koreans at the

12 hearing symbolizes the state of AIDS services among the

13 Korean communities here in the United States.

14 As a caveat I would like to state that as I

15 would not profess to represent the entire Asian Pacific

16 Islander communities, you know, I would similarly not

17 profess to represent the entire Korean community.

18 But before I begin to talk about direct

19 services offered here in San Francisco I would like to

20 raise some observations about the Korean community in the

21 United States and present for the record here some fact

22 sheets and a brochure produced here in San Francisco which

23 is I believe a model of culturally sensitive basic AIDS

24 educational brochures. And it is the only brochure funded

25 by the government through a Korean center in the United

1 States.

2 First I would like to talk about the Korean

3 community in terms of its immigrant rate. The Koreans

4 have the second highest immigrant rate of all Asian and

5 Pacific Islander groups in the United States.

6 In terms of how recently Koreans have

7 arrived 90 percent of the Korean population has arrived in

8 the United States within the last 11 years. Homophobia is

9 a big issue.

10 Homophobia in combination with a lack of

11 social services for Koreans has made basic AIDS education

12 very difficult to deliver. And finally, as I have stated

13 before, there is only one Korean social service center in

14 the United States which has been funded to produce

15 education and prevention materials. A Korean community

16 service center in San Francisco. They have been funded to

17 produce one brochure and one poster -- which unfortunately

18 I wasn't able to bring.

19 Now, I would like to talk a little bit about

20 direct services for Asian and Pacific Islanders in the

21 United States -- which is not a highly developed or

22 examined area.

23 And the information that I am about to

24 present is primarily drawn from my own perspective as

25 having managed the direct services program here in San

1 Francisco.

2 To reiterate a point, the Asian and Pacific
3 Islander communities in the United States vary
4 considerably in terms of the development. You can
5 classify them in terms of are they running, walking, or
6 crawling.

7 Regarding AIDS services some communities
8 have yet to develop their own basic AIDS education
9 messages while other communities are able to provide
10 support services to people living with HIV disease.

11 Alienation within communities is tremendous.
12 A person living with HIV disease faces tremendous
13 alienation within their own ethnic and cultural
14 communities.

15 The stigma can be compounded by the
16 revelation that a person has engaged in homosexual sex or
17 has used injection drugs.

18 To my knowledge, the Gappa Community HIV
19 Project's direct support program is the only
20 governmentally funded group in the United States to
21 provide support services targeted to Asian and Pacific
22 Islanders meeting the diverse needs.

23 And the program provides as well as possible
24 services to a wide spectrum of people -- gay, straight,
25 non-sexually identified, active substance users, people

1 with past substance abuse uses, women and some children.
2 Really the heart of the program is the over
3 20 trained volunteers who provide the bulk of services
4 through this program. And actually some people -- Velma
5 and Paul specifically -- work in the program. And other
6 folks in the audience are volunteers with the program.
7 Meeting the diverse needs of the client
8 population the idea involves a lot of networking. I work
9 with a variety of AIDS, Asian and Pacific Islander and
10 social services agencies to begin to try to meet some of
11 the needs of clients. And no one agency is ever going to
12 be able to meet the needs of a client.
13 And finally, I want to talk about some
14 nontraditional methods of providing services. Providing
15 AID support services to what is, I guess, called
16 nontraditional communities involves employing
17 nontraditional methods.
18 In particular, a major component of service
19 delivery involves outreach to publicize services and also,
20 very importantly, to create a trust between clients and
21 service providers.
22 You can match service with a face or you can
23 know where this is going. Without these efforts to
24 outreach the clients services across the HIV spectrum
25 cannot begin to be delivered.

1 And as we try to go for increasing monies to
2 try to expand the services to include people from HIV
3 positive asymptomatic across the HIV spectrum that is
4 something that we really have to stress -- that a good
5 deal of our program will be outreach. A good deal of the
6 program is beginning to -- before we can even intake
7 people to the program we have to reach them and access
8 them. Thank you very much.
9 MR. CHANG-MUY: Thank you, Lori. You have
10 heard testimony from the Pacific Islands, from the East
11 Coast, West Coast. Now, we would like you to hear some
12 testimony about specific groups. Tony, if you will talk
13 about Southeast Asians?
14 MR. TONY NGUYEN: Hi, everyone. My name is
15 Tony Nguyen. And I work for the center Southeast Asian --
16 Settlement. And I can talk a little bit about my
17 background. Okay. I have grown up in Vietnam. We have a
18 big family -- five brothers and five sisters. And I am
19 the youngest and I am gay.
20 That is very different to talk about in a
21 family about -- especially about sex and drug in a family.
22 And the first thing when they know I am gay then they
23 really deny it and really lie, okay -- you are not my son
24 anymore.
25 Then that is really difficult. Then when

1 they find out I am gay then they ask me -- okay, you have
2 AIDS. Then that is a big issue for Vietnamese. Then all
3 my family they try to deny. They try to make up a lot of
4 stories.
5 That is my choice. They don't think that is
6 okay. They think maybe I wake up in the morning and I
7 will tell my father -- okay, today I am to be a gay and
8 tomorrow I wake up and be a straight. They don't
9 understand it.
10 And that is a big issue for the Vietnamese.
11 They don't understand it. They hate the gay people or
12 lesbian or transvestite, whatever. And that is why I am
13 trying to be here with everyone to talk about the culture
14 sensitivity.
15 And also, my job -- I am working for the
16 centers -- I do an outreach worker. Every day I go out
17 and talk to people like in restaurants, one by one,
18 whatever.
19 And the problem I have that more people they
20 don't understand about the condom. They don't think that
21 is the big problem. They don't think they have to use a
22 condom.
23 And they think maybe that not the disease
24 everyone can get. They only think that a gay disease. I
25 mean, after 10 year -- 11 year people still think about

1 that. That really sad. I mean, really scared for me --
2 for myself.
3 When I go out and talk about that then that
4 is the one thing. Then about HIV a lot of it not being
5 HIV positive. Then when we go and talk about that and they
6 don't take -- I have a group of Vietnamese.
7 Then every time we try to talk about gay --
8 everyone have to take a blood test. And the question
9 everyone ask -- after I take the test if I positive
10 nothing to be done to me. I mean, that really important.
11 I mean, they don't think -- they don't trust
12 treatment Western. And that is why most gay men they
13 don't want to take a chance to take a test because the
14 test -- I mean, to be called a positive that is a death
15 sentence. I mean, they think they can die tomorrow.
16 I mean, why you have to worry about that? I
17 can enjoy today, tonight with my partner, whatever. Why
18 you have to worry and take a test. And that a big issue
19 we have to be concerned about that.
20 Also, I am involved with a lot of people. I
21 go inside a lot of massage parlors. I can tell you about
22 in the Tenderloin neighborhood -- have about 15 - 20
23 massage parlor. About 15 up there owned by Vietnamese.
24 Then how many people working in there that
25 we don't know what they are doing inside there. One time

1 I go there and I heard a lot of people tell about -- we
2 don't use a condom, we don't need a condom.
3 The Vietnamese they said now that is not for
4 Vietnamese. That is for American. We don't have that
5 kind of disease. And we don't have any gays Vietnamese
6 die from AIDS.
7 And I can tell we have nine people die from
8 AIDS in San Francisco. And over 200 Asian -- until now.
9 I talked with a lot of people. Yesterday I talked with
10 some doctor. And they don't think that is a disease that
11 everyone can get it. They only think that is a disease
12 for only the gay. Then only for white men. Whatever they
13 said. And that very upset me.
14 I try to do my best. But, you know, the
15 problem we have only one outreach worker in San Francisco
16 -- and only one. And sometimes San Francisco go to San
17 Jose about 50 miles.
18 About 70,000 people Vietnamese live there.
19 They don't know nothing about AIDS. That really basic.
20 My mom one day I come visit her sister. Okay, Tony, you
21 be careful every time you go to public toilet you have to
22 be careful, maybe you can get AIDS from that. That really
23 basic thing. I mean, everyone can know -- doesn't know at
24 all. And that very, very scare me.
25 That is why I am very pleased to be here and

1 hope we can get a lot of agency here -- we talk the same
2 way. We try to -- for Cambodia and Laos. They don't have
3 any people to help them. At least I have one people
4 Vietnamese but they don't have any Cambodian or Laos can
5 speak their language. And they can do a full time job and
6 do outreach.
7 At least can show them, okay -- everyone can
8 get it. That though -- the message. I want to send every
9 single person today. Okay. Thank you very much.
10 MR. CHANG-MUY: Thank you, Tony. For more
11 perspectives on Southeast Asian provision of services,
12 Nga?
13 MS. NGA NGUYEN: Yes. My name is Nguyen. I
14 am a refugee from Vietnam. I have been in this country
15 for 15 years. I have worked for the past 10 years as a
16 public health nurse.
17 And as a health provider I cannot help but
18 being concerned about the lack of information, the lack of
19 knowledge and awareness about AIDS among the refugee
20 population specifically. Because I work with them.
21 But also first generation like me -- you
22 know, my sister, brother, cousins and everyone -- they
23 just don't -- even though they speak English but they just
24 don't want to deal with the issue.
25 There is a lot of talk about diversity here.

1 And I think we need to just kind of bring us all down to
2 the same level because we are all human beings. And
3 Asians, like everyone else, are sexual human beings. And
4 we obviously exhibit the same high risk behavior. And we
5 need to acknowledge that.
6 So, I am very, very concerned. And
7 obviously as a health provider I can see that we are
8 almost like following the same pattern -- if not, we are
9 already, you know -- just developing the same patterns of
10 HIV infection among Asian like in the other minorities
11 like Hispanics and blacks.
12 We certainly share some common factors. We
13 are -- there is low social economic status. I certainly
14 don't see too many rich Asians where I work. And we have
15 lack of access to health services.
16 We have the language and the cultural
17 barriers. So, you know, I am here to say that we need
18 education out there. And I am not just talking about
19 pamphlets.
20 Pamphlets don't teach. We need outreach.
21 We need bilingual ethnic workers out there in the
22 community to work with these populations. We need to be
23 -- the reason I am asking for ethnic and bilingual is
24 because basically that in itself would just kind of --
25 see, I am having problems with language.

1 That in itself would just kind of compensate
2 for the cultural barriers, you know, that we are seeing.
3 You do need to come from -- I, myself, am doing some AIDS
4 education and outreach in the refugee population.
5 And I have to say there is a lot of cultural
6 barriers that we need to work with. And so, being
7 Vietnamese I think is tremendously helpful because I know
8 where these people come from.
9 They have never talked about sex before.
10 They have never dealt with any of these issues. So, you
11 just need to talk with them at their level and just work
12 your way up.
13 And of course there is definite other
14 considerations. But I don't have time to go into. The
15 other issue I would like to make is early intervention and
16 treatment.
17 I think in our community -- in the Asian
18 community, like Tony was saying, diagnosis of AIDS is a
19 death sentence. And a lot of people have not yet realized
20 that early diagnosis and early intervention does help.
21 So, we do need to focus on that in our
22 education. And of course going to one major thing is
23 making health care more accessible. I work at the health
24 department in Arlington County.
25 And the STD clinic that we have I rarely

1 see any Asian, if not any Vietnamese, using that facility.
2 So, I am not saying that we have to go and train everybody
3 to be bicultural and whatever. But we do need to just
4 sensitize the health care providers about the cultural
5 issues.
6 And I think as health care providers we are
7 all aiming at providing effective services. And I thank
8 you for the opportunity to talk today.
9 MR. CHANG-MUY: Thank you, Nga. We have
10 four speakers left. For perspectives on the Filipino
11 community, Jaime?
12 MR. GEAGA: Hi. Yes. My name is Jaime
13 Geaga. I sit on the San Francisco HIV Planning Counsel --
14 which was created as a result of the Ryan White Act. I am
15 also the program director for the Filipino Task Force on
16 AIDS.
17 As was said already by other speakers,
18 Filipinos comprise the largest Asian ethnic group in the
19 U. S. today. I think I have also heard that Filipinos
20 have the highest incidence of AIDS not only in San
21 Francisco but also in New York -- which I wasn't aware of.
22 And I think also in Los Angeles.
23 That information -- I don't know what that
24 information is for in other cities like Chicago, Texas and
25 Hawaii -- if they are published.

1 What I would like to talk to is how maybe
2 here in San Francisco we have tried to bring to bear the
3 diversity of our Asian and Pacific Islander communities
4 that we are trying to impress on the Commission to not
5 only appreciate and acknowledge but also be sensitized and
6 actually hopefully to translate into policies that will
7 have tremendous impact on how delivery of services goes to
8 the client.
9 In San Francisco we have ethnic specific HIV
10 prevention programs as well as services which I think the
11 policies of the health department in collecting data that
12 is ethnic specific has helped us to see what the incidence
13 rates have been.
14 Not only do we have ethnic specific
15 programs, we also have had some surveys that have been
16 conducted to establish baseline data on the knowledge,
17 attitudes, beliefs and behaviors of the Chinese community,
18 the Japanese community and the Filipino communities.
19 We also have baseline data on the knowledge,
20 attitudes, beliefs and behaviors of Filipino gay and
21 bisexual men along with Latino, Hispanic gay and bisexual
22 men and Native Americans.
23 Now, this I think are all very important in
24 terms of assisting our work. We have this baseline data
25 to determine whether our work is effective two - three

1 years from now.

2 But unfortunately I think this is only
3 unique to San Francisco and not at all to other parts of
4 the country, as we have heard across the room. And I
5 think that is the problem I would like to highlight as I
6 talk about our efforts and work here in San Francisco and
7 how we have tried to really implement as we have taken the
8 responsibility to take our diversity and address it in its
9 detail.

10 Because as we talk about the big picture it
11 is really -- the end result is the client who is very
12 specific and ethnic specific however. And that is what
13 makes a difference.

14 So, I think diversity has to be translated
15 to data collection. You know, national policies have to
16 be established to begin to reflect that so it has some
17 influence on the local level. Maybe not for San Francisco
18 because we already have those enlightened policies in
19 place.

20 The same way heterogeneous, et cetera. The
21 problem with maintaining the status quo of just leaving it
22 on the level of Asian and Pacific Islander is that it puts
23 the onus on our communities to figure out how to divide
24 the very scarce and small resources that we have to begin
25 with.

1 And it is easier for the legislators -- the
2 policymakers -- to kind of just lump us all up into one
3 big category and not have that full appreciation of how we
4 are going to implement these programs in the concrete.
5 That is the implication of the status quo. I think that
6 is my main point. And I hope I have gotten my message
7 across. Thank you.
8 MR. CHANG-MUY: Thanks, Jaime. We would
9 like to conclude with the last three speakers by shifting
10 to general issues. Dorothy will talk about education and
11 funding issues. Dean will wrap up with language. And
12 John will conclude with issues affecting youth. Dorothy?
13 MS. WONG: Okay. Good morning. I would
14 like to welcome the Commissioners and the other panelist
15 members to San Francisco. My name is Dorothy Wong. And I
16 am presently the program director for the Asian AIDS
17 Project.
18 And we provide education, prevention and
19 outreach services to the Asian Pacific Islander
20 population. We have language capability in Mandarin,
21 Cantonese, Tagalog and Thai.
22 And in addition to the general community we
23 have offered to outreach to primarily monolingual
24 immigrant gay, bisexual men and outreach to API substance
25 abusers.

1 And we have been able to access a lot of API
2 women in the sex industry -- which includes street
3 prostitutes, women in the massage parlors.
4 San Francisco AIDS services have been touted
5 as the model program in the country. And I think a large
6 measure of its success is due to the community support
7 that has developed to rally around fighting this epidemic.
8 I think in the Asian Pacific Islander
9 community, you know, we are several years behind fighting
10 the epidemic in relations to all the other communities.
11 Largely because the numbers did not show up in our
12 population until later in the epidemic.
13 But I wonder -- there is a part of me that
14 guessed that Asian Pacific Islanders were affected from
15 the beginning but due to a lot of the cultural issues that
16 we have to contend with that a lot of the Asians did not
17 report that until they were too sick and, you know, just
18 had to get care.
19 Today there are about 210 cases -- reported
20 cases of AIDS in San Francisco with over 80 percent of
21 those cases being gay and bisexual men. And, as you
22 heard, we are just beginning to develop those services to
23 meet that need. I mean, direct support services are just
24 recently funded.
25 And now we are starting to look at what

1 early intervention what sort of medical services are
2 needed for our population.
3 I think what particularly concerns me is
4 that now with funding becoming very tight and very
5 competitive that I am beginning to notice that funding
6 sources are beginning to prioritize what will be funded in
7 the future around AIDS services.
8 And I am particularly concerned that because
9 the Asian numbers are low that we will have a lower
10 priority for funding for all spectrum of services in our
11 community.
12 And I think that is the real concern.
13 Because the rate of increase in our community -- it is
14 increasing. I mean, in San Francisco the API community
15 has the highest rate of increase in reported AIDS cases.
16 And you have heard about the diversity of
17 the API population. And I also want to highlight the fact
18 that the API population in San Francisco constitutes
19 almost 30 percent of the population. And that is a
20 significant number of people to consider a low priority.
21 Another issue I wanted to deal with was the
22 issue around the importance of education. I think there
23 has been enough testimony here to talk about, you know,
24 the large degree of misconception that is still prevalent
25 in our community.

1 I think the issue around the difficulty in
2 talking about AIDS in our community. And we are just
3 starting to make headway. I think it is encouraging to
4 see the large number of people that have turned out to
5 testify. You know, I think it highlights that the
6 community is turning around.
7 But I think that we still have a long way to
8 go. And now is not the time to stop funding us, you know.
9 You know, the issue around the model minority -- you know,
10 you have heard that many, many times. And I think a lot
11 of it is often perpetuated by our own community.
12 You know, I think our community -- it is
13 very much in our culture to present our best image and not
14 to air our dirty laundry before the public and before
15 other communities.
16 I think for me personally while there are
17 many values and beliefs in my culture that I am proud of I
18 think I find it very disheartening to see a cultural
19 belief and value that is contributing to the detriment of
20 my community. And that is something that we have to
21 contend with as AIDS educators.
22 And I think in that sense the Asian Pacific
23 Islander community is fighting not only the AIDS epidemic
24 but its own community. So, I really hope that the
25 Commission will look at the issues that we are contending

1 with and take into consideration the work that we have to
2 do and not have us be a low priority in future funding for
3 services. Thank you.
4 MR. CHANG-MUY: Thank you. Dean?
5 MR. GOISHI: (Japanese phrase.) Good
6 morning. My name is Dean Goishi. I am a sansei, third
7 generation gay Asian Pacific Islander, Japanese American.
8 I am a product of Camp 3, Poston, Arizona. Even though I
9 have less hair I am younger than Suki is.
10 I am project director for the Asian Pacific
11 AIDS Education Project in Los Angeles. This is a
12 consortium of six Asian Pacific Island agencies and
13 organizations providing bilingual HIV education and
14 prevention programs in seven Asian Pacific communities --
15 Chinese, Japanese, Korean, Filipino, Thai, Vietnamese and
16 the gay Asian Pacific communities.
17 We are also providing unofficial educational
18 materials in Cambodian, Lao and the Tongan communities. I
19 am also the chair of the AIDS intervention team of the
20 Asian Pacific Lesbians and Gays.
21 The Asian Pacific Lesbians and Gays is an
22 organization formed 10 years ago. And the AIDS
23 intervention team was formed over three years ago to
24 provide HIV education and prevention information to the
25 gay Asian Pacific community in Los Angeles.

1 Aside from the denial of HIV and the
2 homophobia and -- you might say -- homoignorance existing
3 within the Asian Pacific communities language remains one
4 of the highest barriers to effective HIV education and
5 services and HIV health care.
6 In Los Angeles and Southern California there
7 exists the most diverse numbers of Asian Pacific
8 communities in the United States mainland. In 1988 over
9 24 separate and distinctly different Asian Pacific
10 communities were identified -- all speaking different
11 languages and dialects.
12 Los Angeles has some of the largest numbers
13 of specific communities outside of their home countries --
14 Tongan, Samoans, Koreans, Cambodians, Vietnamese, Laos,
15 and so on.
16 In the 1990 census we showed that there are
17 one out of 10 persons in Los Angeles County are of Asian
18 Pacific background. And that is probably undercounted.
19 Of this Asian Pacific population most are recent
20 immigrants.
21 And these communities continue to grow in
22 numbers. In order to reach 90 percent of the communities
23 we have to speak 10 different languages. Of those I
24 mentioned we have to add Samoan.
25 Almost all of these communities there are

1 large monolingual populations. Over 90 percent of the
2 Vietnamese, Cambodian, Lao and Thai communities are
3 monolingual.
4 Over 80 percent of the Korean, Chinese,
5 Filipino communities have two other dialects in Los
6 Angeles -- are 80 percent monolingual.
7 To be diagnosed with HIV diseases in Los
8 Angeles County and not be able to speak English is a
9 disaster and a very heartbreaking situation. A very large
10 number of Asian Pacific Islanders infected with HIV rely
11 on the county system for medical services.
12 Many go to their family doctors because of
13 the language situation. However, they have to go to the
14 county system for HIV services. There are very few Asian
15 Pacific Island doctors that are knowledgeable in HIV.
16 There are too many other health concerns is their reason
17 -- TB, hepatitis, general family practices, et cetera.
18 HIV is too new for them. They do not have
19 the time to learn about HIV infections. I know of only
20 three Asian Pacific physicians involved with HIV in Los
21 Angeles. There is 1-1/2 in research and 1-1/2 in with
22 private patients.
23 Asian Pacific Islanders are reluctant to
24 seek medical help and go to the county systems and will
25 only go to the county systems when they are too sick and

1 have no other alternative methods of health care.
2 Reluctance to seek early interventions stems
3 from, one, not knowing about early intervention programs
4 and, two, the language barrier about HIV infection and all
5 of the issues surrounding HIV.
6 Once in the county system they do not have
7 any type of Asian Pacific Island language support for
8 themselves or their families. For these service providers
9 to say that they do the best they can by providing any
10 staff member to interpret or translate be they nurses,
11 administrative staff, cooks, or even gardeners is totally
12 inadequate.
13 Knowing the high level of negative stigmas
14 associated with this disease, HIV infection, and gay
15 issues just to have anyone translate is extremely
16 intolerable and terrible.
17 I may recommend to this Commission that
18 federal funding -- that the Commission promote federal
19 funding directly to the local organizations to develop or
20 expand existing volunteer programs such as we have with
21 the AIDS intervention team of providing HIV knowledgeable
22 and gay sensitive pool of translators.
23 Eighty-six to ninety-one percent of persons
24 living with HIV infection in Los Angeles are gay or
25 bisexual Asian Pacific Islanders. Our study in 1989

1 showed that 64 percent were Asian Pacific born PWAs, or
2 persons living with HIV.
3 Federal funding is necessary passed directly
4 to the local agencies and not through state or county
5 agencies because we tend to become diluted and lost in
6 that process because our numbers -- quote, unquote -- are
7 just too small.
8 Presently in Los Angeles the AIDS
9 intervention team is the only Asian Pacific Island
10 organization trying to meet some of the needs of Asian
11 Pacific Islanders.
12 Through voluntary funds from donations and
13 fundraisers we have HIV positive support groups. We just
14 received some funding to do support groups in the
15 monolingual languages of Chinese, Japanese and Tagalog
16 dialects.
17 We have also an emergency financial
18 assistance fund where because Asian Pacific Islanders will
19 most likely exhaust all their personal resources before
20 asking for or seeking help that they are just completely
21 destitute.
22 It normally takes around 30 to 60 days to
23 get into any type of service providing agencies. And by
24 that time they have no rent money, they have no food
25 money, et cetera. So, we do provide a little bit of that.

1 We also have been able to establish an
2 ethnic food assistance fund where Asian food staples not
3 found in the regular food banks are made available -- such
4 as Asian rice, soy sauce and seasonings.
5 A medical assistance fund has also been
6 developed and is currently being used. It is used for
7 both Western medicine as well as Chinese herbal medicine
8 which has proven to be, for us anyway, very effective and
9 has helped keep the health situation -- or keep them from
10 getting more sicker, you might say. Sorry for that
11 English.
12 There are many other issues that I would
13 like to address. For instance, did someone mention the
14 Asian women and how to deal with Asian women and the
15 sexual -- what do you call it -- sexism in the Asian
16 Pacific communities.
17 Translation materials for early intervention
18 programs, antibody testing campaigns, safer sex practices
19 and negotiation programs. We have been told that we
20 cannot do because we have enough translations.
21 And we have to show that we can reach a
22 certain number of people in our programs. And we were
23 told that this is CDC mandated. Is he still here? And
24 with that, thank you very much.
25 I do like to close with a question to the

1 Commission. And basically it is that you have heard us
2 today and I would like to know what the Commission can do
3 and will do for the Asian Pacific communities and how soon
4 we can expect that to happen.
5 With that, I would like to close but I would
6 like to take one more minute. I would like to address
7 Eunice's question earlier about the translated materials.
8 In our first -- three years ago when we just started our
9 translation programs we did consult with the home
10 countries.
11 We did consult with the consulates that are
12 located in Los Angeles. We received several translations.
13 We only got one from each country. And that was the only
14 official AIDS materials at that time.
15 The reason why we did not look at it or use
16 it is because the translated materials is very derogatory
17 toward gays, the characters that are being used, the
18 terminologies and the phrases are extremely negative
19 toward both the HIV infection methods of transmission and
20 the actual description of gay people.
21 In Chinese I believe it was brought up that
22 the actual sexual acts were translated to chicken sex.
23 The terms for gay people are referred to as sexual
24 deviants. This goes through almost every of the Asian
25 Pacific translations that we looked at. And that is the

1 reason why we cannot feel comfortable about using
2 materials that are developed in our own countries.
3 MR. CHANG-MUY: Thank you, Dean. Before we
4 give the Commissioners a chance to answer Dean's question
5 on how you are going to follow up we would like to
6 conclude with John Manzon's last testimony on youth.
7 MR. MANZON: I was going to say good morning
8 but it is good afternoon. My name is John Manzon. I am
9 the son of working class Filipino immigrants. And I am a
10 gay man.
11 And I want to say that I am here because I
12 feel the support of especially the Asians and Pacific
13 Islanders in the room. And that is the only way that I am
14 able to give this testimony. I would also like to welcome
15 my sister, Bonnie, who is in the audience.
16 Doing HIV work has been difficult without
17 family support. So, that is why I am welcoming her
18 specifically. I would also like to mention another family
19 member, my grandfather. He went to law school in New York
20 State but was not allowed to take the bar exam because
21 there was a law barring Filipinos from taking the bar
22 exam.
23 So, I think it is ironic that I am here as
24 an advocate for Asians and Pacific Islanders when he as
25 his career wanted to do that and was not able to in this

1 century.

2 I am currently a crisis counselor, advocate
3 and case worker at Project Reach, a community based youth
4 drop in center in New York City's Chinatown. I am here to
5 talk about the young people that I work with and to offer
6 another perspective so that you all walk away with the
7 model minority mythology sufficiently exploded.

8 The population of young people -- the Asian
9 young people that I work with are mostly mainland Chinese,
10 Hong Kong Chinese, Taiwanese, but also Thai, Cambodian,
11 Vietnamese, Malaysian and Korean.

12 Most of them are lower income from the inner
13 city and receive public assistance. Some are runaways,
14 some are homeless. The Asian American youth that I work
15 with are in gangs, they drop out of school, they get
16 arrested, they get physically and sexually abused at home,
17 they suffer depression, they commit suicide, they deal
18 with unwanted pregnancies, they take crack and cocaine,
19 they come from HIV infected families and they contract HIV
20 themselves.

21 And they are not the model minority that
22 everybody considers Asians to be. In terms of specific
23 approaches it goes without saying that young people at
24 different ages of immigration, as other people have said,
25 require different strategies, different outreach

1 techniques.

2 If you don't have vocabulary in English for
3 words like sex, vagina, penis, lesbian and gay -- if you
4 don't have them even in your native language, it is very
5 difficult to discuss issues such as HIV.

6 For other recent immigrants only in their
7 native language can HIV prevention and education occur.
8 But while printed materials are critical -- especially in
9 a city like New York City where the API communities are 87
10 percent recent immigrant -- for young people -- again,
11 depending on the age of immigration -- they won't read
12 materials.

13 They may read comic books about it but there
14 aren't any yet. If they are literate in their native
15 languages, then -- if they are not literate in their
16 native languages, something in the language of their
17 parents won't make any sense for them.

18 I work with a 19 year old young man from
19 Malaysia. He came to this country undocumented at age 12.
20 And he hasn't been to school since age 12. He was
21 abandoned by his father and speaks poor English. And
22 these are the young people who need to know about HIV
23 education. And these are the young people where we have
24 to focus our energies and develop those programs not yet
25 developed. He needs to hear the information since he

1 won't be able to read it.

2 A couple words about outreach and

3 dissemination of information. A lot of people talk about

4 school-based programs and school-based efforts. A lot of

5 young people that I work with aren't in school. They --

6 or cut school rather frequently.

7 And so, whatever dry stuff they get in

8 school it won't be if they are not there sitting in the

9 classroom -- they are not going to hear it. And even if

10 they are there in the classroom, it is not that they

11 internalize it because of all the cultural factors that

12 people have brought up before me.

13 Many, in fact, know the facts. But they

14 regurgitate them with -- if you will pardon the expression

15 -- a straight face because they don't feel that it really

16 endangers their lives -- the threat of HIV.

17 And the reason that is so is because of one

18 basic faulty assumption -- that HIV might be the only

19 thing wrong. I want to share a few stories. And I will

20 use fake names.

21 May is one of four sisters. She is the

22 third of four sisters. The older two had run away because

23 the father beat them. She is suicidal and abused often.

24 Another young woman, Jennifer -- she is 19.

25 She left home because her brother beat her up. And now,

1 she goes out with the leader of a Chinese gang.
2 Brenda, one of four sisters -- she came when
3 she was 8 years old. Her mother is on welfare. And she
4 lost her virginity when she was 12 to a member of a gang.
5 Ricky, who is 16 years old -- a refugee from
6 Cambodia. He was arrested and sentenced to a year and a
7 half in prison.
8 When young people are dealing with all the
9 issues that they have to deal with HIV becomes -- you
10 can't try and convince a young person to say this could
11 kill you when things are killing them already.
12 I want to bring this to the floor because
13 HIV prevention is inseparable from teen pregnancy
14 prevention and from gang prevention and dropout
15 prevention.
16 Young people generally don't have much
17 control over their lives. We need to look at problematic
18 family situations and insensitive school systems and
19 general lack of support.
20 We have to look at what is pushing young
21 people to engage in high risk behavior. In the very least
22 someone to talk to, a safe space -- where problems with
23 parents and sexual behavior can both be discussed.
24 So, I as a service provider am doing HIV
25 prevention work by default. We are not funded for doing

1 HIV. But whether it is dropping out of school or hanging
2 out in gangs or attempting suicide or entering sexually
3 premature relationships or engaging in unsafe sex or drug
4 use they have put themselves at high risk for HIV.
5 HIV in the population that I work with
6 highlights the incredible lack of services. And I cannot
7 underscore it enough that it is the latest life
8 threatening reality for the young people that I work with
9 and for a lot of our Asian and Pacific Islander
10 communities that aren't adequately addressed.
11 So, when we talk about HIV issues we are
12 really talking about a lot of unaddressed health issues in
13 general that we face as Asians and Pacific Islanders. We
14 need funding. We want bodies for outreach. We want
15 bodies for translation. We want bodies to reach the
16 communities. We don't want bodies to make our counts more
17 legitimate so that we can be more affected by this
18 epidemic.
19 One last thing about the model minority. It
20 is a manipulated minority that we are. Manipulated so
21 that we can seem that we are okay and we are not okay. At
22 least the young people that I am dealing with are not
23 okay. And it is because they are rendered invisible by
24 this model minority mythology. It cannot continue. Thank
25 you.

1 MR. CHANG-MUY: Thank you, John. We are
2 pretty much on time. And we would like to thank the
3 Commissioners for ---
4 DR. OSBORN: I am sorry. We are on time in
5 one sense. But I am going to have to sort of take over
6 quickly now because we have 10 people who want to talk to
7 us in public comment as well. So ---
8 MR. CHANG-MUY: Would you be able to answer
9 Dean's question before we hear from the public?
10 DR. OSBORN: I will answer it in a certain
11 sense. That is why I interrupted you. Because I don't
12 want to leave you completely disappointed. I will
13 disappoint you with my answer however because it would be
14 unwise for a commission like us wanting to hear, absorb
15 and digest things that we have heard to give quick answers
16 to that kind of question.
17 What we try to do as a commission -- our
18 sole power is the power of persuasion. We don't have pots
19 of money. We have long since been advocating increased
20 resources.
21 You can and have helped and have given us
22 some good things to think about in terms of ways that
23 resources can be used effectively. And we will be looking
24 at that as we develop recommendations both to the
25 executive and to the congress.

1 But I always worry -- particularly with a
2 question such as you asked -- that people may imagine that
3 we have some magic way of helping. And all we can do is
4 promise to listen. I think the Commissioners have
5 listened as carefully as we can to you today. And then,
6 try and be sure that we are as astute as we can be in
7 factoring the very important input that you have made into
8 recommendations that we see strategically may be helpful
9 in a given context with either the congressional or the
10 executive initiatives that are ongoing or that we can
11 suggest. As we have with things like the Americans With
12 Disabilities Act.
13 We were very upfront in other instances. If
14 we can lend a word of support, we do. So, we will promise
15 you to try to be as helpful as we can. I must say I am
16 pleased from some of the comments that have been made that
17 you have done some very important things in group
18 interaction just by being here.
19 And it is one of our hopes in having
20 hearings such as this that that kind of dynamic can also
21 be helpful. That we haven't wasted your time by bringing
22 you here to talk to us when we feel in some ways as
23 powerless as you do -- because you have, in fact,
24 interacted so richly today.
25 So, I am sure that is not what you wanted to

1 hear me say. But I think in the interest of process and
2 time we probably ought to -- again, let me express my
3 great gratitude to our moderators, to the group that has
4 been so forthcoming with personal difficulties that we do
5 appreciate.
6 And we need to move on because in terms of
7 absolute time we are very far behind and have quite a lot
8 of other things this afternoon.
9 MR. CHANG-MUY: Thank you.
10 DR. OSBORN: Thank you. I kind of
11 interrupted you there so I could move us along. Did you
12 have ---
13 MR. CHANG-MUY: No. I just wanted to thank
14 the Commissioners for taking testimony. I wanted to ask
15 you to answer Dean's question. And if there are 10 people
16 who want to comment, let's hear them.
17 DR. OSBORN: Good. As I did yesterday, I
18 know some of you may have tight schedules and we don't
19 want to imprison you in your seats having participated
20 with us all day. On the other hand, you are most welcome
21 to hear the public comment with us and stay comfortable --
22 unless you have pressing schedules.
23 I am going to ask the people to try and stay
24 within two minutes each for public comment. Always people
25 have a great deal more than two minutes of important

1 things to tell us.

2 And so, I always feel uncomfortable asking

3 that. But we have had a very rich day of testimony. And

4 if you can find ways to focus our attention very sharply

5 on your major one or two points, we will probably be

6 better for it than if it takes a little longer.

7 With that having been said, I am going to

8 also apologize for my inability to do justice to some of

9 the names -- and handwritings. The first person who would

10 like to speak is Bonnchon Thepksuysane. Am I saying that

11 recognizably?

12 And I think what I will do is just before

13 you start I will ask David Cho to come to the other

14 microphone so that we don't have transition time problems.

15 And I appreciate your being willing to talk briefly to us.

16 PUBLIC COMMENT

17 MR. THEPKSUYSANE: Thank you, Commissioners.

18 My name is Bonnchon Thepksuysane. I have a very long

19 name. And I work for the Asian Health Services as a

20 community health worker and health educator.

21 I want to highlight some few points. But

22 most of the points I have written it in the statement

23 already. So, to make it short the few points that I want

24 to make here is -- I am speaking here on behalf of the

25 newest communities -- which is the Laotian, Mien and

1 Cambodian communities. The reason I say the newest is we
2 are here in the United States for less than 15 - 16 years.
3 My experience working as a community health
4 worker in my own community there are still lot of deny and
5 frustrations about the fact that we don't get enough
6 information about AIDS, how to learn about it, how to seek
7 help from certain services. Things like that.
8 We don't speak the language. Most of our
9 community members don't speak the language. I tell you
10 the experience I have in the classroom when we do the AIDS
11 presentation.
12 We do the outreach as well. When we get in
13 touch with them through the service providers like job
14 training programs and things like that. We go to the
15 classroom.
16 So, we divide it up into certain groups of
17 people. We have the staff who speak certain languages
18 like Chinese, Vietnamese, Laotian and Mien. Things like
19 that.
20 But when we go over there when we start --
21 here we are. We coming from Asian Health Services. We
22 want to talk to you guys about -- to educate you about
23 AIDS.
24 And suddenly the faces of the participants
25 or audience gets stuck. And some of them even laugh at

1 it. They feel embarrassed and ashamed. You can't just go
2 there to the classroom and talk about AIDS but you have to
3 start with build up the relationship, build the trust.
4 Where you came from.
5 Maybe you start about five or ten minutes
6 talking about where you came from and what is your
7 background and things like that. And then, later on the
8 trust was there.
9 And then, I started talking about it. And
10 then we showed a videotape and things like that ---
11 DR. OSBORN: Can I get you to summarize
12 quite quickly?
13 MR. THEPKSUYSANE: Okay. Yes. I will. The
14 other thing is there were certain groups who were left out
15 when we provided the -- because we don't have enough
16 languages.
17 For instance, there may be Cambodians over
18 there in the classroom. And some of the people ask why
19 not have the bilingual worker to come to do the
20 presentation.
21 And I have to lie to them that we don't have
22 enough funds to hire enough bilingual workers. We will
23 try to get funds to you. In my heart I feel like I am
24 lying to them. We try to get funds. In our culture it is
25 like lying to them.

1 And the other thing is ---

2 DR. OSBORN: I am afraid we really have run

3 out of time now. And we have nine other people that we

4 need to hear as well. So, if you have written testimony,

5 we will be very pleased to have that and give further

6 consideration when we have a little more time.

7 MR. THEPKSUYSANE: Okay.

8 DR. OSBORN: Thank you so much for your

9 testimony.

10 MR. THEPKSUYSANE: Thank you very much.

11 DR. OSBORN: And while David Cho is getting

12 ready if Michelle Aldrich would come to the other

13 microphone please.

14 MR. CHO: Hi, my name is David Cho. I also

15 work for Asian Health Services as a Chinese community

16 health worker. About six weeks ago a 46 year old HIV

17 positive monolingual Chinese man was referred to me.

18 He is unemployed, uninsured, has been living

19 in the United States for more than five years but has

20 never seen a Western doctor. He is living by himself. He

21 is very isolated.

22 He is very weak and skinny, has been sick

23 for three months with consistent fever and fatigue, lost

24 15 pounds. And still it took him all this time to get

25 help.

1 Why would a person wait three months to get
2 help? We at Asian Health Services had to refer him to
3 Highland General Hospital. You know why? Because we do
4 not have the money. We simply -- not that we don't want
5 to do the work. Simply because we do not have the money
6 to provide HIV services.
7 Immediately I called Highland Hospital and
8 tell them my poor patient have to wait for additional
9 three weeks for an appointment. When he asked me to go
10 with him to the appointment I explained to him that there
11 is going to be a translation.
12 But he still wanted me to go. I went with
13 him and I am glad that I went with him. Because there is
14 no way that he -- that this poor guy could have gone
15 through the whole thing by himself.
16 With his physical condition and language
17 barrier he is just not able to find his way in the
18 hospital running from wings to wings, floors to floors and
19 rooms to rooms.
20 While we were waiting at the registration
21 counter he suddenly started to feel very sick. He was
22 coughing. He was having shortness of breath. And it was
23 not a pleasant situation for both of us.
24 And at Highland or any general hospital the
25 problem lies on the lack of culturally and linguistically

1 appropriate staff. And I know I am not speaking just for
2 myself.
3 I know this is difficult. But it is
4 possible. It is not impossible that we do the work. That
5 is directly quoting from Mr. Lei Chou. You give us the
6 money. We will show you how we work. We will show you
7 how much we can do.
8 And, to conclude, with a rapid growing API
9 population in the county and the state I really, really
10 think that funding is in dire need for implementing
11 clinical care as well as culturally and linguistically
12 appropriate services among Asians and Pacific Islander
13 population and Asians serving -- and clinics. Thank you.
14 DR. OSBORN: Thank you very much. Michelle
15 Aldrich. And then Douglas Varanon.
16 MS. ALDRICH: Madam Chairman, Commissioners,
17 staff and invited guests, AIDS is the first epidemic the
18 world has had to deal with since polio. The problem of
19 prevention and education is that AIDS put America in
20 conflict with the issues that America has not been able to
21 deal with on an objective basis.
22 The issues of discrimination of people of
23 color and people who are infected with HIV. The issues of
24 sexuality -- gay, lesbian, bisexual and heterosexual. The
25 issues of drug use, the distribution of bleach, needle

1 exchange and the medical use of marijuana.
2 The issues of homelessness, poverty,
3 morality, criminality, homophobia, health care policy and
4 the exclusionary policies of our government. In truth the
5 majority of the people in the United States are
6 minorities. Whether divided by geography, culture, color,
7 sexual orientation, or the ability to pay, every group has
8 the right to know the facts presented in a culturally
9 sensitive manner in which language that the population can
10 understand.
11 Laws do not make the person change their
12 behavior or lifestyle. The war on drugs actually promotes
13 the spread of AIDS. Who will survive this epidemic?
14 Criminals who smoke marijuana so they can eat when
15 affected by the wasting syndrome or by the toxicity of
16 AZT. People who change their sexual behavior by use of
17 condoms against the mandates of their churches. People
18 who have access both medically and financially to drug
19 treatments that may prolong their lives.
20 Life is a valuable entity and no member of a
21 selected population is disposable no matter what the
22 reason. The definition of AIDS must be expanded to
23 include medical problems that are unique to women. Women
24 must be included in clinical trials. We must be
25 inclusive, not exclusionary.

1 AIDS is a preventable disease. But this
2 pandemic requires nontraditional responses. Education
3 must be on the cutting edge concerning sexual activities
4 and drug use without moral overtones.
5 Nonjudgemental education assists people in
6 responding responsibly and independently to changing their
7 behavior. Medical and social outreach -- like the
8 barefoot doctors in China -- will do more to bring health
9 education to the people who otherwise could not be reached
10 because of their distrust of the medical model.
11 Prevention efforts now will prove to be more
12 cost effective and humane than the budgetary saving
13 methods now being used without regard to the consequences
14 of the future. This epidemic ---
15 DR. OSBORN: Could I ask you to summarize
16 and then ---
17 MS. ALDRICH: I am.
18 DR. OSBORN: --- we would be pleased to have
19 that made available to the Commissioners in full.
20 MS. ALDRICH: Yes. This epidemic provides
21 people with the realization of the inner connectivity of
22 humanity. This epidemic gives people an opportunity to
23 bring reality based education without discrimination into
24 the 21st Century.
25 I urge the Commission to be brave and bold

1 and to have the courage to provide the leadership that is
2 needed to defeat the virus that is changing everybody's
3 life it comes in contact with. Our primary objective is
4 to stop the spread of HIV. Everything else is secondary.
5 Thank you.
6 DR. OSBORN: Thank you. After Douglas
7 Varanon -- Willy Wilkinson will be next.
8 MR. VARANON: I would like to thank the
9 Commissioners for being patient with this testimony.
10 There are a couple of points that I would like to bring
11 out.
12 One is that the lesbian, gay, bisexual Asian
13 and Pacific Islander community I feel has been silenced
14 yesterday by being absent from the testimony. And
15 although the issues were mentioned today, I don't think
16 that it was addressed in a very substantial way.
17 And not all Asian and Pacific Islander
18 lesbian, gay and bisexual people hang out in the same
19 place. There is a lot of different cultural nuances. And
20 so, some of that needs to be investigated and examined in
21 terms of how to do HIV education, prevention services for
22 the communities that are mostly being impacted. So, to
23 that end I would encourage the Commission to allocate
24 funding for gay and bisexual Asian and Pacific Islander
25 community based organizations.

1 I would also like to request a report from
2 this meeting today. And just to highlight the fact that
3 we are taxpayers. Many of us cannot vote because we are
4 not citizens. And we are relying heavily on you to convey
5 our message to the White House, to congress so that we can
6 impact institutional changes which promote behavioral
7 change in the Asian and Pacific Islander communities.
8 We need to encourage you to mandate cultural
9 competency in the provision of HIV services, fund research
10 and documentation of our diverse cultures. Our movement
11 here is an outgrowth of the civil rights movement which
12 focuses on the African American community. And API
13 communities with immigration and languages are impacted
14 differently by racism in this country.
15 I would request that you promote
16 collaborative efforts. I served on a statewide HIV
17 comprehensive care working group and applaud the Ryan
18 White legislation which mandates half of the funding of
19 Title II to go to collaborative efforts.
20 And to that end also I think that in order
21 to collaborate as a group we have to be able to put
22 forward our perspective -- our own cultural perspective --
23 which hasn't really been developed yet. We are still in
24 the process of doing that.
25 And with funding from the federal government

1 we can accomplish that. Perhaps through maybe an Asian
2 and Pacific Islander symposium on AIDS which highlights
3 different cultural perspectives and results in a
4 publication which can be widely distributed to all HIV
5 service providers -- particularly those with Asian and
6 Pacific Islander populations in their geographic service
7 area.
8 I would also like part of this symposium to
9 explore cultural aspects of the different lesbian and gay
10 bisexual Asian and Pacific Islander communities. Because
11 Filipino immigrant gays or the transsexual or transvestite
12 don't necessarily communicate -- or don't interact with
13 Hong Kong gays, or something like that.
14 DR. OSBORN: If I could ask you again to
15 summarize? We really are pressed for time. And I am
16 sorry about that.
17 MR. VARANON: Okay. So, in order to
18 intervene, you know, we just need the data available that
19 gives us the information on how, when and where it is
20 appropriate to be. Thank you.
21 DR. OSBORN: Thank you. After Willy
22 Wilkinson is Sam Akinaka.
23 MS. WILKINSON: Hi, my name is Willy
24 Wilkinson. I am a health educator and a community health
25 outreach worker with the Asian AIDS Project in San

1 Francisco.

2 And I would like to thank the panelists here

3 today for the issues that have been brought up --

4 especially Joanna Omi for speaking to the issue of hoppa

5 people. Because as mixed heritage people we are

6 oftentimes excluded from the communities that our

7 heritages are of.

8 And to Martin Hiraga for speaking to that

9 otherness. And to Sharon Lim-Hing for speaking to the

10 issues of lesbians and HIV. I think as lesbians we are

11 very hungry for that information on women to women

12 transmission.

13 I am a street based AIDS educator. I work

14 in the Tenderloin, Chinatown and South of Market with

15 injection drug users or sexual partners, women and

16 transgender people who work in the sex industry.

17 And AIDS is really just one more crisis in

18 these people's lives. They are not necessarily going to

19 pick up the phone and ask questions or go to other service

20 providers for help.

21 So, I think this work is so vital because I

22 may be their only connection to this information. While I

23 am helping them with their survival needs I am giving them

24 bleach and condoms and other safe sex materials and saying

25 okay, with a nonjudgemental approach -- whatever you do,

1 be safe. That is what I do every day.
2 It is hard to measure this work. But the
3 reality is people tell me -- you know, you may have saved
4 my life. You know, I used to not really think about
5 bleach every time. I thought maybe once in a while but
6 every time now. And this is a sexual partner of a
7 Filipino client of mine.
8 And, as Suki Ports said, women really are
9 more at risk as being infected by men than men are by
10 women. And I would also like to say that women in massage
11 parlors tell me -- well, if the john is Asian then maybe
12 I won't ask them to use a condom. Because there still is
13 that myth that Asians do not get HIV.
14 So, I would just like to underscore the need
15 for outreach work in our communities and for funding for
16 education and prevention. It is so necessary. It is so
17 vital for our community survival. And it is cost
18 effective. Thank you.
19 DR. OSBORN: Thank you. After Sam Akinaka
20 Vinne Sales will be following.
21 MR. AKINAKA: Good afternoon. My name is
22 Sam Akinaka. And I am a member of the Asian Pacific AIDS
23 Coalition of San Francisco. And I work for the Bay Area
24 Asian Research and Treatment Program which is methadone
25 maintenance and detox programs in the state of California.

1 Up until recently -- in September I
2 transferred into administration. I was the clinic
3 director for the largest methadone clinic in California --
4 which is based here in San Francisco for having worked at
5 that site for 13 years.
6 We unintentionally I think perpetuate some
7 unintentional racism. It is not intended. But to mention
8 this issue about minority when in fact in many areas like
9 in San Francisco we are quickly becoming a majority. We
10 might be larger than the other ethnic groups inside that
11 local area, as Hawaii has pointed out.
12 But there is many places -- especially with
13 the new immigrant populations coming in -- there are
14 actually much larger groups. And unfortunately because of
15 this it is cultural that we do not -- that we trust our
16 leaders. That we do not make waves. And in terms of
17 societal problems are only defined by what the community
18 considers a problem that we are underrepresented in terms
19 of services based on the population in those particular
20 areas.
21 For Asians in particular we have a problem
22 with subcultural and majority cultural denial not only
23 around AIDS but substance abuse. And that area it is like
24 hand in hand in terms of the AIDS epidemic. And not just
25 with iv drug use.

1 With many Asians it is not iv drug use. It
2 is the primary problem in the community. But substance
3 abuse as a whole is very large as a problem.
4 I would like to mention something briefly
5 about some of our clinics in Fresno. There is a large
6 Hmong population. And in Fresno we probably have the
7 largest group of opiate addicted Hmong in treatment in the
8 United States.
9 And what our clinic directors found there
10 was that they would try to treat the Hmong that would seek
11 treatment. And the Hmong would say -- populations in
12 general -- but might say -- yes, yes, yes. And in fact
13 not understand anything about, in this case, substance
14 abuse. They also discuss AIDS issues too. And eventually
15 decided to hire a Hmong at both of the clinics.
16 And when you look at -- I know the model is
17 working towards trying to consolidate some of the monies
18 and the resources. But in areas where there is
19 significant Asian populations those significant
20 populations need to have the representation integrated
21 into the services because they are not integrated into the
22 mainstream society or powerful enough in terms of dealing
23 with their cultural issues to present the issues
24 themselves. And we need to affect those populations too.
25 Thank you.

1 DR. OSBORN: Thanks very much. After Vinne
2 Sales Rafael Chang from the Shanti Project.
3 MR. SALES: Good afternoon to everyone. My
4 name is Vinne Sales. And I am the program associate at
5 Asian AIDS Project. And I also do health education and
6 prevention in the gay bisexual community here in San
7 Francisco.
8 I would like to emphasize to the Commission
9 that the voices that you hear today are the more
10 articulate voices in our community. The people that we
11 serve in our community have probably far less education
12 and far less privilege than those who are here today.
13 I would also like to emphasize that the
14 trend in funding nowadays is moving towards more early
15 intervention and case management direct services. And I
16 would like to tell the Commission that the Asian community
17 is lagging behind in terms of education and prevention.
18 And services geared towards these education
19 and prevention don't have to be undercut because funding
20 is moving towards case management and direct services. We
21 have performed KABB studies -- knowledge, attitudes,
22 beliefs and behavior studies -- in our communities. And
23 the information is out there.
24 However, behavior is not necessarily being
25 changed. And unless that funding continues for education

1 and prevention behavior that necessitates taking care of
2 ourselves and preventing ourselves from being infected by
3 HIV won't be necessarily implemented. Thank you.
4 DR. OSBORN: Thank you. Rafael Chang. And
5 then Michael Foo. I have more trouble reading than
6 pronouncing I think. Welcome.
7 MR. CHANG: My name is Rafael Chang. I am
8 an Asian gay man. And I work for Shanti Project -- which
9 you may or may not be aware of. We do emotional and
10 practical support services to the gay white male
11 community. That is my main clientele.
12 I also service some people of color
13 communities. These people of color communities come from
14 not wanting to access their own community based agency --
15 if there are any in the first place -- because they don't
16 want to be stigmatized by their communities.
17 I wanted -- given the wonderful testimony
18 that was given today, if you look around this room this is
19 about 50 percent of the direct service workers that you
20 see in this country. This is it. Okay.
21 And I also didn't want you to leave -- or
22 any of us here -- without remembering four people within
23 the last two months that I have worked with. And I will
24 use pseudonyms.
25 There was Michael who was 22 years old. I

1 first met him two months ago. And he was from Thailand in
2 the intensive care unit. He died three days later of
3 AIDS.
4 There was Dave who I also met the same day
5 who is Filipino. With lesions and both his legs so
6 swollen that he couldn't walk anymore.
7 There is Johnny who is from Singapore whose
8 lover just died recently. His visa ran out this January
9 and is now facing deportation. And he also does not know
10 his HIV status.
11 And last Wednesday Tim Wong died, Chinese,
12 28 years old. Of AIDS.
13 DR. OSBORN: Thank you, Mr. Chang. Michael
14 Foo. And then after that Fred Guisande.
15 MR. FOO: I thank you, Commissioners. My
16 name is Michael Foo. I am the project coordinator for
17 Gappa Community HIV Project. I am 46 years old, American
18 born Chinese. I grew up in Hawaii. I am gay. And I am
19 also HIV positive.
20 I share this with you because I would like
21 to talk about some myths that I have come across here in
22 San Francisco about gays in the Asian Pacific Islander
23 community and how AIDS impacts us.
24 I suspect these myths may exist in other
25 parts of the country. Myth No. 1 is that homosexuality is

1 not part of the Asian culture. Well, I grew up with
2 mostly Asian friends and schoolmates.
3 I had no role models. I grew up in the '50s
4 and '60s before the Stonewall revolution. I did not know
5 what gay was. But I just knew that I was attracted to
6 men.
7 The second myth I would like to talk about
8 is that Asian Pacific Islander immigrants -- particularly
9 recent immigrants -- do not engage in an unsafe sex
10 behavior. For example, they do not engage in anal
11 intercourse. They learn it from their exposure to white
12 Americans here in the United States.
13 Well, I did not learn to have anal
14 intercourse from white Americans. I learned it with my
15 cousins who were my age at the age of 11. We taught each
16 other.
17 The final myth I would like to talk about is
18 that Asians and Pacific Islander gay and bisexual men if
19 they would only keep to themselves would not be at risk of
20 AIDS. It is only those who relate with whites or African
21 Americans or Latinos who are at risk of contracting AIDS.
22 This may have been true very early in the
23 epidemic but it certainly isn't true now. There is
24 sufficient cases and exposure among Asian Pacific
25 Islanders that we are quite capable of transmitting it

1 among ourselves.

2 The last thing that I would like to do is to

3 address Commissioner Goldman's question about when does

4 cultural sensitivity become racism or sexism. First I

5 would like to talk about the issue of sexism.

6 As a gay man it does not matter to me

7 whether my doctor is a man or a woman as long as he or she

8 is sensitive to my needs as a gay man. Regarding racism,

9 service providers have the responsibility to deliver

10 services to their clients in a manner such that the

11 clients understand what is happening to them and can also

12 communicate to the service provider what their needs and

13 concerns are.

14 Therefore, when you have someone who is

15 foreign speaking the most appropriate way to address and

16 serve that particular client is to speak in the language

17 that they grew up thinking in. Not just speaking in, but

18 thinking in.

19 The other alternative is if the client is

20 bilingual and the service provider only speaks English,

21 then that service provider has a responsibility to use

22 English that is common to the level of English that that

23 client is capable of. So, I don't see racism as being a

24 threat when we ask for cultural sensitivity. Thank you.

25 DR. OSBORN: Thanks for your comments. Fred

1 Guisande. And then Mr. Ed Lee.
2 MR. GUISANDE: Commissioners, everybody,
3 good afternoon. I know we are all pretty tired. I am. I
4 am 34 years old. I am also HIV. I am not a health care
5 worker. This afternoon we have heard from all sorts of
6 health workers, grant writers, everybody pulling money to
7 work within this industry.
8 I just want everybody to get sort of
9 grounded on the fact that this is affecting lives. It is
10 affecting my life. It is affecting many lives in here
11 which we all have been touched by.
12 I deal with my health care issues by going
13 to Washington, D. C.. I am the only Asian person in a
14 study that I know of. I have always wondered and asked my
15 white doctors and white nurses and health care people back
16 there why isn't it that NIH is doing anything for HIV
17 infected Asians.
18 And they always told me -- well, this is
19 information that we can't give out -- blah, blah, blah.
20 And that my big question is -- why isn't there any Asians
21 here. I am still asking that question.
22 I have been going there for 2-1/2 years.
23 The way I address the health care industry is that I have
24 to jump through hoops. If I want your AZT, I have to take
25 your AZT. If I can't afford it, I have to join -- I have

1 to get involved in some sort of group -- controlled group
2 to get my medicine.
3 I can bring up a lot of issues. And I only
4 have two minutes to do so. I am really dissatisfied. I
5 am dissatisfied with the outreach that Westernized
6 medicine is doing towards Asian men, Asian women.
7 I am really dissatisfied with NIH. I wish
8 you guys would lean heavy on them and do something about
9 it. I would like to talk with one of you maybe during
10 lunch and get to know you or you can get to know me as a
11 person. Not to theorize or what to say or what to think
12 to do in the future. Thank you.
13 DR. OSBORN: Thank you. Mr. Lee.
14 MR. LEE: Dr. Osborn, members of the
15 Commission and panelists and service providers, my name is
16 Edwin Lee. And I am the director of the Human Rights
17 Commission for the City and County of San Francisco.
18 And I wanted to extend my welcome here of
19 this very, very important topic and certainly to join with
20 this Commission to do all we can to fight discrimination
21 as well.
22 We have heard a lot today about the lack of
23 funding and the lack of support to break the barriers of
24 ignorance. And most oftentimes those barriers of
25 ignorance translate themselves very vividly into very

1 horrible acts of discrimination in employment and housing.
2 And we are doing all we can at this local
3 level in bringing our expertise to fight discrimination as
4 well as sharing that expertise throughout the counties in
5 the Bay Area.
6 So, I wanted to just quickly thank you for
7 being here and welcome to San Francisco. And working with
8 you and all of us -- we will enjoy doing that closely in
9 the next few years.
10 DR. OSBORN: Thank you. That is a nice
11 ending and a nice opportunity for me to thank those of you
12 not only from San Francisco but from a great many places
13 both now and bicultural background for sharing with us.
14 I do believe the Commission has learned a
15 lot. And I think we were very inspired by the leadership
16 that many of you are clearly giving to your communities in
17 difficult times.
18 I think I speak without having to check with
19 the Commissioners. I can assume their feeling is as
20 strong as mine that if we were able to enhance funding for
21 the important programs you have described, if there were
22 any way to do that, we would. And we will if we can find
23 ways to argue effectively.
24 Because it is quite clear that there is a
25 great deal of human need and a good deal of precious life

1 involved in the issues that we all care about. With that,
2 I am going to adjourn now.
3 The Commissioners are going to have to have
4 a working lunch. So, I am sorry we can't take you up on
5 your good invitation. But we have some more work that we
6 have to do. But thanks to all of you for coming.
7 (Whereupon, at 1:15 p.m., the hearing was
8 recessed, to reconvene at 2:30 p.m., this same day.)
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1 A F T E R N O O N   S E S S I O N

2 2:30 PM

3 DR. OSBORN: I think we are as here as we are
4 going to be. We have commission business. Is everybody
5 set to consider some commission business things for a
6 little bit here? Maureen, shall I turn the floor over to
7 you for that?

8 COMMISSION BUSINESS

9 MS. BYRNES: Thank you. I have a couple of
10 things on a list that I thought I would basically provide a
11 status report on, and then see if there are any issues that
12 you have for us that we need to be taking care of prior to
13 the June meeting.

14 The first is, for those of you who may not
15 have heard, our consultant on the Chapter IV,
16 Responsibilities of the Different Levels of Government, has
17 received the wonderful honor of being named the new Health
18 Commissioner for the State of California.

19 So, while Molly has promised us that she will
20 complete the chapter that we were counting on her to work
21 on with us, she will not be working with us for the rest of
22 the summer.

23 But I know that both Dr. Konigsberg and Diane
24 and Mike and Jim Allen, we have figured a way in which we
25 can provide some contact and feedback to Molly's latest

1 outline and she will be getting a final draft to us by the
2 end of the month.
3 And it is my expectation that she will also
4 be with us on June 6 in Colorado. That may well be the
5 last time we get to spend a whole lot of time with Dr. Coy.
6 But I feel certainly quite comfortable with the fact that
7 she will fulfill our expectations in terms of the chapter,
8 provide us some guidance and will be available on the 6th
9 of June to chat with us about how that chapter fits into
10 the overall context of the comprehensive report.
11 We are moving along fairly well, I think, on
12 the rest of the report. The consultants know that we have
13 a deadline of May 31 for the next draft of the chapters so
14 that we can send those out to you so that you can have had
15 a chance to read them before the 6th of June.
16 It is my understanding that the meeting that
17 Pat Franks had with a small group of commissioners who were
18 interested in the prevention section went quite well
19 earlier this week.
20 And we will be working between now and
21 probably the next couple of days to get invitations out to
22 some of the individuals identified in that meeting to
23 participate in what we call a staff briefing on issues
24 around prevention on May 30 in Washington, D. C.
25 It is my expectation that there are a number

1 of commissioners who are planning on attending. And you
2 are all more than welcome to do that -- it is May 30 in
3 Washington on issues of prevention -- in addition to any of
4 the members who have identified prevention as being a
5 review No. 1 priority for you all. We will keep you up to
6 date on who the participants for that meeting will be.
7 We also still have planned a meeting tomorrow
8 morning here at the hotel from 9 until 12 with Jeff Striker
9 and some members of the research and general San Francisco
10 community about research and clinical trial concerns.
11 Any of you who will be here for the weekend
12 and want to join us, we will be in the Tower Room, I think
13 -- I am not sure if that is right. Is it the Tower Room?
14 All right, the Tower Room from 9 to 12
15 tomorrow --
16 DR. OSBORN: I think it is Lombard.
17 MS. BYRNES: Is it Lombard? I think it got
18 changed. That is why I sort of hesitated. It is Lombard,
19 not the Tower Room.
20 DR. OSBORN: They must be close to each other
21 on the 6th floor in Building 3. But it is the Lombard Room
22 which is the one I have written down.
23 MS. BYRNES: And because we changed the room
24 back and forth a few times, I did ask Frank to be sure the
25 concierge desk knew where the National Commission on AIDS

1 research meeting is tomorrow morning.
2 So, for anybody who wants to come, or if you
3 know of anyone else who is going to be joining us, just
4 make sure they double-check with the concierge desk. We
5 will leave where we are with the desk so that they know
6 about that.
7 It is still my hope, and maybe it is still
8 Ellen's and my hope, that we will get a draft of a
9 substance use HIV report to you. We have had some
10 scheduling problems with Don DesJarlais and are anxious to
11 get some feedback to him prior to sending a draft out to
12 you.
13 I think again that might be something we will
14 need to talk about at the June meeting to see where we are
15 in terms of your opportunity to have read a draft and see
16 what the timing would look like to releasing such a report
17 prior to the comprehensive report at the end of the summer.
18 I had checked with a few schedules and, sort
19 of in my usual fashion, tossed a few dates out in one of
20 the more recent letters to see if we could find a couple of
21 dates to schedule an additional meeting in July at the
22 request of some of the commissioners at the last meeting,
23 in addition to trying to pinpoint a day that we would
24 release the comprehensive report, and schedule a meeting
25 for September.

1 I did get feedback telling me from a number
2 of people that that second date in July, which I think was
3 like the 30th or the 31st, would not work for a few people.
4 And also that a couple of commissioners were going to have
5 some problems with the September 4 date as the day that we
6 release the comprehensive report.
7 And I guess at this point I would like to
8 look to you for some guidance as to how you would like for
9 us to proceed. Should be continue to look for an
10 additional meeting date in July?
11 And how best should be go about trying to
12 find a day where I know many people who are involved in
13 academic calendars, as well as Eunice has identified a
14 fairly large-scale conference that would conflict with the
15 4th of September, how we might be able to come up with a
16 day that maximizes commission participation obviously for
17 the release of our most comprehensive report.
18 But I am beginning to feel like I am not sure
19 how from D. C. to orchestrate getting a date that we can
20 all be in D. C. to release the report.
21 MS. DIAZ: Could you just refresh our
22 memories about the need for the meeting in July? What was
23 that to accomplish?
24 MS. BYRNES: A couple of commissioners at the
25 last meeting thought that the July 10th and 11th meeting,

1 which is dedicated to basically looking at a final draft if
2 you will of the comprehensive report, didn't provide an
3 opportunity for everyone to see together another final
4 draft if there are comments at that point in time.
5 We will be coming together for two days to
6 have read the report, to give feedback to the consultants,
7 feedback to the staff. And then the desire to be able to
8 see then what the final product looks like prior to going
9 to the printer.
10 And I think it was Diane and some others who
11 suggested it might be a good idea for us to have another
12 meeting to essentially sign off on the final product. That
13 is how that came about, Eunice.
14 MR. GOLDMAN: I think there was also a
15 concern that, even if we were able to finalize
16 satisfactorily the report on July 9th and 10th, there was
17 the question of executive summary and when that was going
18 to be done and ready, and it might not be done until after
19 we decided on -- it is hard to do a summary until after you
20 do a report.
21 If we agreed upon the report on the 9th and
22 10th, then the executive summary might follow it. And that
23 might be an opportunity to review that.
24 MS. MASON: Could you speak a little louder?
25 MR. GOLDMAN: I am sorry. If we finish the

1 report, assuming that we finish the report and there is no
2 further need for review of it on July 9th and 10th, there
3 is still the question of the executive summary that
4 accompanies it. And that might be appropriate for review
5 at that later time.
6 MS. DIAZ: Don, 9 or 10, or 10 or 11?
7 MR. GOLDMAN: Well, whatever the dates are.
8 I am sorry, I --
9 MS. BYRNES: All right, it is 10 and 11.
10 MS. DIAZ: Thank you.
11 MR. GOLDMAN: Up to now it is 10 and 11. And
12 I am sorry, I didn't make that clear. But that was the
13 other thought, just to have extra time in case there were
14 substantial revisions on the 10th and 11th to the report,
15 that there would be time to have those revisions made and
16 then to review the final product as it looked at that
17 point.
18 DR. OSBORN: Larry?
19 MR. KESSLER: I am going to say this in the
20 hopes that it is not misinterpreted but it probably will
21 be. I am uncomfortable talking about a September date for
22 the issuance of the report without a broader discussion or
23 something about a plan for the report.
24 Because it may not be that we need all the
25 commissioners for the issuance but we may need

1 commissioners for other pieces of the plan.

2 And by setting a date now it seems to have
3 become the conclusion that there will be some sort of a
4 press conference and the report will be issued that day.

5 And my fear is, the way things have been
6 going in this country, if we pick the wrong day and
7 something else happens, the president has a palpitation or
8 Dan Quayle trips coming down the plane, we will get what we
9 have got wiped off the front page and we won't get a second
10 date.

11 So, I guess I would like to have a discussion
12 at some point, maybe when Tom has an outline or is ready to
13 lead us in that discussion, at a point where we can talk
14 about the whole strategy. And then see who is available
15 for what pieces of the strategy, and so on.

16 But simply saying September 4th makes me
17 uncomfortable. Because we can't predict what else will
18 happen September 4th.

19 MS. BYRNES: I had asked Tom to prepare
20 essentially a proposal for the plan around issuing the
21 report for our June meeting in Colorado. But what you say
22 makes a lot of sense to me, Larry.

23 MR. DALTON: It makes sense to me, too. I
24 also wanted to suggest that, in addition to thinking about
25 a press strategy, we also ought to think about a strategy

1 for how it is that we want this report to be used by
2 Congress and the White House and whether there are steps we
3 should take to make that happen.
4 So, it may not just be Tom. Maureen, you of
5 all people it seems to me have a fair amount of expertise
6 in thinking about what we might do upon release of the
7 report to make sure that the right committees know about it
8 in advance, that people are available to talk to them if
9 that it is appropriate. But some mechanism to --
10 MR. BRANDT: Yes, the strategy we are talking
11 about is a strategy that is much beyond just press.
12 Because it does engage the Hill, it engages the communities
13 we have been involved with in developing the report, it
14 involves perhaps the White House, and so there are a lot of
15 pieces ot it.
16 And Larry's point is well-taken, that there
17 are a lot of pieces that will need to fit together beyond
18 the press conference itself. And there is as much art as
19 there is science sometimes in timing those things because
20 you can be bushwhacked by events beyond your control.
21 You can plan a certain amount using your best
22 guidance as to what you can anticipate occurring in the
23 news cycle that day. But you can always get surprised by a
24 trip on the helicopter steps.
25 DR. KONIGSBERG: I would like to support both

1 Larry and Harlan in the comments that they made. Somebody
2 has used -- it may have been Larry -- the marketing
3 strategy. And I really would like to reinforce that this
4 is more than a press strategy.
5 MS. MASON: I am sorry, I can't hear you.
6 DR. KONIGSBERG: I think this is more than a
7 press strategy. I really would like us to give some
8 thought, I don't know when we do that, to a serious
9 political strategy. And that is a broad base, that is not
10 just Congress. I think there are other ways, but that is
11 certainly part of it,
12 As to how we want to get our messages that
13 will be in that report to where they will be effective.
14 Something different than the President's report which was
15 fine but basically has stayed on shelves of state health
16 officers and other various characters. It hasn't really
17 been used actively.
18 And I think we would all walk away from this
19 commission feeling like we had failed if we don't carry
20 forward the messages that we will have. And I think we
21 really need to give some thought to that.
22 The press conferences, we do that. We will
23 have to do that. But there is that risk that we will get
24 upstaged by various things.
25 MS. BYRNES: I think what I would like to

1 suggest and also ask for your feedback on this, we have not
2 talked about this on a staff level. So, anybody who wants
3 to go crazy when you hear me say this, feel free.
4 Our schedule is fairly full, even though it
5 is three days in Colorado. We are looking at issues around
6 Women in the HIV Epidemic, one day devoted to really
7 talking with the consultants about the substance of the
8 report and how it is organized, and then some issues around
9 civil rights, with the understanding that we are ending on
10 a Friday and that most people in terms of flights usually
11 need to be getting away by around 2 or 2:30 on a Friday
12 afternoon to go back to where we all come from.
13 I might suggest that if we have this
14 discussion around strategy that we try to organize
15 something over dinner the first night or something like
16 that. Because I am not clear about where the time that
17 really devoted to this kind of discussion might be right
18 now.
19 If that is comfortable -- right, we will have
20 to look for a night that would work.
21 MR. KESSLER: What is going on the first
22 night?
23 MS. BYRNES: There may be a reception from
24 the Governor of the State of Colorado the first evening.
25 And we, as a staff, are going to be meeting with the

1 consultants the second night.
2 We need to go back and look at this in terms
3 of time. My point is, I want to provide enough time for us
4 to have this conversation, yet we already have a number of
5 things on our plate.
6 MR. KESSLER: Maybe what would work is, since
7 people are coming from the east, mostly I think from the
8 east to the west including the staff, leaving the east
9 coast at 8 or 9 or even 10 that morning gets you into
10 Denver by noon to 1 o'clock.
11 And if we could meet from say 3 to 5 that
12 afternoon before the reception, and also come --
13 MR. ALLEN: Larry, is that the 4th? You are
14 talking about traveling on the 4th?
15 MR. KESSLER: Whatever that date is. I am
16 not sure, what is the date?
17 MS. BYRNES: The hearing is on the 5th.
18 MR. KESSLER: You are going to be traveling
19 on the 4th anyway.
20 DR. OSBORN: I am booked solid until the last
21 flight. I certainly can't. I will be right in the middle
22 of my budget hearings for the school of public health and I
23 can't do it. I am already out three days that week and I
24 can't be gone.
25 MR. GOLDMAN: The other option is to put it

1 on for the 7th.

2 MR. KESSLER: I can't do that.

3 DR. OSBORN: Yes.

4 MS. BYRNES: Is there a possibility it could
5 be the second night? I think we need to go -- I guess to
6 some degree I just wanted to share with you that we really
7 have a lot to do in June.

8 I think as a staff we can go back and try to
9 find out how to present that to you in terms of time for
10 the discussion. Your agenda may look quite full when we
11 send it to you for June for that reason.

12 As I said, we were going to get together with
13 the consultants the evening of the second night to pull
14 together much of what we heard with them during the day.
15 We'd need to do a little rescheduling.

16 DR. KONIGSBERG: Well, you know, Maureen, I
17 guess I am feeling a certain amount of frustration here
18 which we have talked about before in that we are moving
19 ahead with a three-day set of hearings.

20 We have got a third year when we could have
21 taken up some of these issues and now we can't find the
22 time to figure out what the hell we are going to do the
23 third year. I don't know the way out of the dilemma right
24 now. Canceling the hearings is obviously not the way to do
25 it.

1 But I guess I will have to say that that
2 frustrates me if we are going to be together three days and
3 maybe the best we can do is find a cocktail hour some way
4 which is not necessarily -- you know, talk about trying to
5 hear each others' talking, it is hard at dinner tables.
6 That is fine for a group of three, four, five, six people
7 but not all of us with staff.
8 And I don't know what we are going to do
9 about it. But we will be into the third year before we
10 have figured out what to do. But it seems to me that that
11 marketing strategy is the most important thing. Maybe we
12 could have dealt with that this afternoon.
13 MS. DIAZ: Is there a possibility that if the
14 meeting ends early that those that are interested stay from
15 2 to 5 and --
16 DR. KONIGSBERG: That never works.
17 MS. DIAZ: That never works?
18 DR. KONIGSBERG: And in three days, I -- I
19 mean, I can't even find the time to go into the mountains
20 which I dearly love. I have got to go home.
21 (Discussion off the record.)
22 DR. OSBORN: The reason I spoke up was in
23 part because I am sure I am not the only person for whom
24 being out of the office three days is already very
25 difficult. I was just using my example. No, I don't mind

1 if you go ahead without me.

2 But on the other hand, I think it is a little

3 hard for me not to hear the discussion since, whether I

4 like it or not, I am probably one of the executors of what

5 you come up with.

6 And it is a little easier if I have heard that

7 because otherwise I could misrepresent the commission

8 inadvertently. So, I don't think it is a particularly good

9 idea.

10 But the bigger reason I spoke up is that I

11 think, as I say to our audiences all the time, we have

12 full-time jobs. My three biggest departments at the school

13 of public health are going through budget review. And 36

14 hours before that the three-day session starts. And I

15 think that others are probably in a similar kind of time

16 constraint.

17 DR. KONIGSBERG: The 4th is not a good day.

18 MS. SOSA: What don't we do the commission

19 business before we do the report with all the consultants?

20 Because that is the entire day for the consultants.

21 MS. BYRNES: Could you use the microphone?

22 MS. SOSA: I am sorry. What about -- there

23 is three days. The first day is women. The second entire

24 day is to discuss the report.

25 What if we started early over breakfast and

1 took a hour and a half to have this discussion? We did it
2 in Washington, the whole day for the report, but took two
3 hours for business first.
4 I sort of checked with Karen who thought we
5 could do that. Does that make sense? We would have all
6 day, the 6th, to discuss the report but we would start
7 early, 8 o'clock, and do 8 to 10 this discussion?
8 MS. BYRNES: All right.
9 MR. KESSLER: I think it can be done in two
10 hours because people can even prior to then if they have
11 some ideas feed them to Tom so that they can be on flip
12 charts or whatever. Rather than start the brainstorming
13 then, we should conclude it then by people coming prepared.
14 MR. BRANDT: We can prepare some outline
15 material for a step-off for the discussion. And then we
16 can sort of modify it, fill in, adjust, rearrange, you
17 know.
18 But we will hopefully come to a fair amount
19 of closure at that point, starting with the input that we
20 are developing right now and getting from you in the next
21 couple of weeks.
22 MS. SOSA: That is one thing I would
23 encourage. We in external affairs are working on that
24 strategy. And if you will encourage the commissioners to
25 call us if it is possible. Some of you already have. So,

1 yes, we have got a lot of what you are saying already. We
2 have discussed that.
3 DR. OSBORN: Don, you have been wanting to
4 say something?
5 MR. GOLDMAN: Yes, I just wanted to say,
6 first of all, I think the extent to which the two hours
7 will be productive and sufficient time will depend upon the
8 extent to which we get input to Tom prior thereto and the
9 extent to which Tom and the rest of the staff can present
10 us with a complete as possible set of recommendations.
11 And it may be something that we can take a
12 half hour to and say, gee, it looks terrific and it is
13 fine, and let's go on with it.
14 The other point I want to make is -- and this
15 goes to the September meeting -- while I agree with
16 everything that Larry and Harlan and Charles said about
17 wanting to put together a plan before setting up a date,
18 the fact of the matter is that setting up dates for members
19 of this commission is an extraordinarily difficult task.
20 The further advance in time that we do so the
21 more likely it is that people will have been able to
22 accommodate their schedules accordingly. And I don't think
23 that -- obviously, June is the chair and David is the vice
24 chair and Maureen is the executive director. They are I
25 suppose the essential people who have to be there, and Tom,

1 in terms of a press conference.

2 But the fact of the matter is, I would hate
3 to have a situation where we finally put together a
4 strategy in June, agree upon it, and then try to find a
5 date in September and find that certain commissioners are
6 not available. And then have them feel that in some way or
7 another they are being left out of the process.

8 And I think it is important that if you want
9 to be flexible, then you have to understand that to the
10 extent that you already fill up your busy schedule, then
11 you ought not to be in a position to complain later on that
12 you weren't given enough notice to rearrange your schedule
13 to be available.

14 You can't have it both ways.

15 MS. DIAZ: Could I just say something? I
16 think that probably that particular meeting will be one of
17 the most important to try to get as many commission members
18 to participate.

19 And some of us took your letter very
20 seriously, Maureen, and answered immediately indicating if
21 we had conflicts with those days. I think even before we
22 leave here, most of us know our September schedule.

23 We could redo that again for you and perhaps,
24 as someone suggested, there is some key individuals that
25 have to be there. But the rest of you, you could see. I

1 don't think we have recently done a summer schedule for
2 you. We did at the beginning of the year. But most of us
3 don't have appointments through September at the beginning
4 of the year.
5 Would that be beneficial if we left that in
6 your hands or the hands of staff today?
7 MS. BYRNES: Sure, Eunice. I think again
8 that we should go back and figure out a way. If that would
9 be helpful for us to have a better sense of what people's
10 availabilities are --
11 MS. DIAZ: Yes, that is all.
12 MS. BYRNES: -- for the month of September.
13 And then as we are putting the strategy together, we have a
14 sense of who is available when.
15 I would also say, bring your calendars. As
16 we put the strategy together, we should probably also be
17 talking about who is available for what, who wants to have
18 more participation in which part of the strategy.
19 But we can go back and figure a process by
20 which we find out if there are a few days in the month of
21 September. And I mean a few, because it may mean that
22 there is more than one day that we are talking about.
23 MS. DIAZ: If we left that with you today,
24 would that be helpful?
25 MS. BYRNES: That would be great.

1 Three other issues of business for me. One,
2 I also wanted to remind everyone that June and Harlan and
3 again, any members of the staff and commission that want to
4 join us will be meeting with Norm Nickens and other members
5 of the N-MAC staff and board at 5 o'clock this afternoon in
6 the Sutter Room, which is in Tower 3. And check with me
7 and I can let you know how to get there.
8 But, of course, everyone is welcome to join
9 us. And then I wanted to mention, and I know a number of
10 commissioners have been in touch with him, but since I had
11 a conversation with him on Sunday I assured him I would
12 send his greetings and express his regret that he wasn't
13 able to be here.
14 But Don Schmidt wanted very, very much to in
15 some way participate in our hearing here in San Francisco.
16 And we have been in fairly constant contact with Don and
17 some people in Don's life.
18 And when I spoke with him on Sunday and he
19 indicated to me that he would not be well enough to travel,
20 I did tell him that I would share his greetings with all of
21 you and let you know how much he wanted to be here.
22 I also spoke with David Rogers this afternoon
23 and, Don, I don't know if you would like to speak to this?
24 And I can then officially let everyone know what David's
25 conversations and thoughts were.

1 Or if you would like to talk about the
2 immigration issue?
3 MR. GOLDMAN: Yes.
4 MS. BYRNES: I know you had a particular
5 interest in it. And I would be happy to turn the mike over
6 to you.
7 MR. GOLDMAN: Fine. Thank you very much.
8 On immigration, let me -- David is fine. At
9 least when I called him I interrupted his gardening. And I
10 assume that is a --
11 MS. BYRNES: He yelled at me, "Just fine."
12 MR. GOLDMAN: He said he is feeling better
13 and all of the other indications were such that he seems to
14 be feeling better.
15 But, essentially, let me -- Jim, you can
16 please fill in -- but as Yogi Bera said, "It is not over
17 until it's over." And our battle with immigration issues
18 that started back in November of 1989 is still not over and
19 we are still in a battle.
20 My understanding is that the Department of
21 Health and Human Services and Lou Sullivan and Assistant
22 Secretary Mason have been stalwart supporters of good public
23 health and been good doctors and have been good public health
24 leaders in this battle.
25 And it continues on in an arena of OMB and

1 Justice and the White House and all of those other intriguing
2 areas that I don't really fully understand.
3 I have the following. David spoke to Lou
4 Sullivan today and indicated that at least for the present
5 time there doesn't appear to be anything necessary for us as
6 a commission to do right now.
7 Not withstanding that being the case right now,
8 I would like to urge this commission -- at least, I think it
9 exists already but I just want to reaffirm it and unless
10 anybody objects -- in the event that some action is needed.
11 Remember that if there are no regulations
12 effective published by June 1, there are real problems
13 because then theoretically anyone even with infectious
14 tuberculosis could come into this country.
15 And, clearly, from a public health perspective,
16 that would not be an appropriate thing to do. Somebody who
17 is potentially infectious at that level with tuberculosis
18 at least I think the CDC has determined, has got to be
19 barred.
20 Is that correct, Jim?
21 REV. ALLEN: Right.
22 MR. GOLDMAN: And so if there are no
23 regulations, nobody is barred. And that is wrong. So, there
24 is a whole lot of pressure to actually do some regs. And
25 there may be some need to do something.

1 And what I would like to hope is that June, on
2 behalf of the commission, could be authorized to do whatever
3 may be necessary in terms of writing letters, telegrams,
4 dancing on the White House lawn, or whatever might be
5 necessary or appropriate to reaffirm the commission's
6 position in this area.
7 And I would assume, unless hearing anything to
8 the contrary from any members, that that authority would be
9 implicit.
10 MR. DALTON: I don't have any problem with
11 that. What I am not understanding -- maybe I missed
12 something -- what is the problem? What is the stumbling
13 block? I mean, I heard you say that a lot of people were
14 being stalwart.
15 I heard you saying that there are a lot
16 institutional and other reasons why there would be some regs
17 by June 1. Now what is the problem?
18 MR. GOLDMAN: The problem as I understand it is
19 that there are individuals in the Justice Department and
20 perhaps the White House who may not be entirely happy with
21 the medical recommendations coming out of HHS and may be
22 upset about the political and economic ramifications of those
23 medical determinations.
24 MR. DALTON: And so what we are asking June to
25 do is what?

1 MR. GOLDMAN: What we are asking June to do is
2 that if it should become necessary and appropriate and if,
3 for example, Lou Sullivan should say, "Help," that June
4 would be authorized to write a letter.
5 If Lou, for example, should say, "A letter from
6 you, June, or the commission to President Bush would be a
7 useful thing to do. Can you get a telegram out within the
8 next two hours," that June would be authorized to do so if
9 that were deemed to be the necessary and appropriate thing to
10 do.
11 DR. KONIGSBERG: Jim, how many tens of
12 thousands of letters have come in on that issue now?
13 MR. ALLEN: There are approximately forty
14 thousand letters signed by forty-eight thousand people. Of
15 the letters from individuals, 91 percent were opposed. The
16 vast majority mentioned HIV or AIDS specifically. About half
17 of them, 45 percent or so, mentioned the health care costs of
18 AIDS in addition to general concerns about communicability.
19 And -- I don't remember the percentage, it was
20 something on the order of 40-45 percent, also objected to
21 taking off the sexually-transmitted diseases and other
22 various things.
23 I think, more importantly, of the organizations
24 that wrote in including medical and professional
25 organizations, legal organizations such as the American Bar

1 Association, governmental state, local health departments --
2 we got some from ministries of health in other countries --
3 of the organizations that wrote in, 83 percent were highly
4 supportive of the policy and thought this was the right thing
5 to do.
6 The Canadians, incidentally, are also in the
7 process of revising their regulations and are essentially
8 allowing travel by HIV infected people without restriction
9 and the main block against immigration would be one in terms
10 of impact on the health care system and costs for the
11 Canadians rather than issues of communicability.
12 DR. KONIGSBERG: Jim, of the 17 percent then of
13 organizations that were not supportive, can you give us some
14 examples of those?
15 MR. ALLEN: Well, the -- yeah, one that I found
16 particularly interesting -- I certainly didn't review all of
17 them, but there were three state health departments, for
18 example, that objected -- I am sorry, let me take that back.
19 Not state health departments, state medical societies.
20 There was the president of a prestigious
21 hospital affiliated with a major medical center within 50
22 miles of Washington, D. C., who wrote in quite strongly
23 opposed. We had a few things like that.
24 DR. KONIGSBERG: Well, I bring that up because
25 I guess this is going to make Sullivan's job a lot tougher to

1 show courage when the White House would be able to waive 30
2 thousand letters and say, "Hey, the people don't want us to
3 do that."
4 Now, the people in this case we may believe are
5 wrong. But, damn, I am glad I am not facing what Sullivan is
6 on a regulation right now. Maybe I will someday.
7 MR. ALLEN: Yes, and that exactly is the -- it
8 is one part of the opposition, certainly from within the
9 administrative structure, that is blocking approval of the
10 regulation.
11 And it is going to probably be taken right to
12 the highest levels to resolve, at least the highest levels in
13 terms of people interested in the domestic side of policy
14 issues.
15 MS. BYRNES: Are there any objections to Don's
16 proposal that --
17 MR. DALTON: The commission has already taken a
18 position in favor of changing the immigration laws. It seems
19 to me what we are doing is simply rearticulating our
20 position. I don't see what the problem --
21 DR. OSBORN: There wasn't any problem, Harlan.
22 It is just a matter of, we started out long ago with every
23 commissioner in a position to say what that commissioner
24 thought as a member of the commission.
25 But when we make fresh and new statements for

1 the commission, I don't like to seem like I'm racing out in
2 front. And I just said to Don and Maureen that I thought
3 this was a good time to double-check, make sure everybody
4 knows where we stand and is comfortable with my speaking on
5 this issue, if and how it is needed.
6 My assessment is it probably isn't needed
7 because we have spoken clearly in the past. However, one of
8 the reasons that I thought we should talk about it now was
9 because we had at least three people in this morning's
10 testimony say please do something.
11 And I wanted us to have had a chance to refresh
12 our memories and reaffirm where the issue stands. So, your
13 confusion is understandable but it is more my sort of trying
14 to double-dot i's and cross t's rather than any new issue.
15 You are quite correct.
16 MR. KESSLER: I would support Harlan's motion
17 that you feel free to do that, with a slight amendment that
18 you not dance on the White House lawn until after the
19 comprehensive report comes in.
20 DR. OSBORN: Thank you, Larry.
21 MR. PERNICK: Why not give her the option to do
22 it?
23 MR. ALLEN: Maureen?
24 MS. BYRNES: Yes.
25 MR. ALLEN: Can I just mention one other thing.

1 In terms of giving you an idea where things are going,
2 however, within the government, I don't know how many of you
3 Wednesday morning saw the big article in the Washington
4 Times. I never really had a reason before to read the
5 Washington Times. Now I definitely have one not to.
6 Mr. Dannemeyer suggested to the Times that they
7 ask the Public Health Service how many people we were sending
8 to Florence. There was a long article in there. We are
9 given our budget and there are a number of people involved
10 from all of the agencies.
11 We had cut back considerably from San Francisco
12 and Montreal, but we still approved travel for 392 people. A
13 major article in the Washington Times on that that has
14 resulted in both Congressional and Office of Management and
15 Budget screams and immediate request for review in my office.
16 One of the reasons that I wasn't here yesterday
17 is that my office right now is pulling together a major
18 package of materials, trying to justify why the people that
19 we have selected to go ought to be able to go.
20 MR. DALTON: How many people?
21 MR. ALLEN: 392.
22 MR. DALTON: But who is "we"? Who is sending
23 392 people?
24 MR. ALLEN: The Public Health Service.
25 MR. DALTON: Public Health Service.

1 MR. ALLEN: That includes scientists from the
2 HIH and all of the institutes. It includes people from FDA
3 who are responsible for reviewing applications for drugs and
4 vaccines. It includes all of the -- I mean, Jim Kern's shop
5 alone has got 200 people, most of them scientists and
6 professionals.
7 And that doesn't even begin to get into the
8 prevention side of it. Then there are all the Hershel folks.
9 This is an opportunity for people to get together with all of
10 the grantees, to have literally dozens of spin-off meetings,
11 to meet with people without having to travel.
12 I mean, it is a very efficient way of getting
13 an awful lot of business done in a short period of time,
14 regardless of whether the meeting is being held in Boston,
15 San Francisco, Montreal or, in this instance, Florence.
16 DR. KONIGSBERG: What is the cost on that, Jim?
17 MR. ALLEN: The cost for this year will be no
18 more than it was for San Francisco. It will be on the order
19 of 1.5 million, which is about one-tenth of one percent --
20 less than one-tenth of one percent of the --
21 DR. KONIGSBERG: What is the commission
22 planning to spend on staff and commissioners to go to
23 Florence? I guess I am sensitive to the political kinds of
24 things that -- it is so easy to get into trouble.
25 MS. BYRNES: Five staff members have been

1 approved to go, including myself. We will be paying
2 partially for some. I think Eunice travels, Scott and Dr.
3 Osborn. I can tell you what the fees are. They are all the
4 government rates of travel and reimbursement.
5 But it is five staff and I believe three
6 commissioners that we would be paying for. Maybe five staff
7 and two commissioners.
8 DR. OSBORN: I wanted to bring up an issue that
9 I think most of you or all of you with Fax machines are
10 already aware of. And that is that I asked Don Goldman if he
11 would be willing to take over in almost a small working-group
12 mode the careful deliberation of the way we should proceed
13 going into our third year.
14 Intuitively, my sense is that we may want to
15 shift gears at least a little bit. We have been very
16 descriptive in some of our activities and in the writing of
17 the comprehensive report have begun to be more deeply
18 analytical.
19 Clearly some balance is always going to be of
20 use. But how that balance is struck and what issues come up
21 is of course a matter of great concern to all of us.
22 And I thought, particularly in view of the
23 problems that we have been having with calendars and with my
24 very genuine wish that whatever we do represent the
25 commission's full enthusiasm, there is no truth to the rumor

1 that I know what we are going to do in the third year.
2 I don't know what we are going to do in the
3 third year. And I probably have less strongly-developed
4 attitudes about that than the vast majority of members of the
5 commission, at least based on comments that some of you have
6 shared with me.
7 So, I thought it would be a helpful process to
8 have those commissioners who were willing to volunteer work
9 under the leadership other than David and me and try and get
10 a sense of really broad-based creation of that third year
11 agenda.
12 And I am very grateful to Don for being willing
13 to do so. And that having been said, I would turn the
14 process of the floor over to Don.
15 MR. GOLDMAN: Thank you. I would just like to
16 thank Diane and Eunice and Larry and Charles and Scott and
17 Irwin for agreeing to be part of it.
18 I have not heard from Belinda or Don DesJarlais
19 -- I guess he is in Europe -- or Roy, Dr. Peterson and Jamal.
20 And if they want to, they are certainly welcome in every
21 respect.
22 I have been trying just to relate back to the
23 other area, just in terms of trying to get together five or
24 six people -- to try to get together with putting together a
25 meeting time. It is extraordinarily difficult getting

1 everybody's busy schedule. Doing it with five or six people
2 is tough. Doing it with 15 must be an impossibility.
3 In any event, I have come up with some time
4 when we do intend to meet. When and where it is and those
5 who are members of the committee, I would appreciate it if
6 they could try to keep June 22-23-24, that is a Saturday,
7 Sunday, Monday, aside as best as they could.
8 It seems to be the only dates that are --
9 DR. KONIGSBERG: When is that again?
10 MR. GOLDMAN: What?
11 DR. KONIGSBERG: When is that again, Don?
12 MR. GOLDMAN: June 22, 23 and 24. Those dates
13 were mentioned in my memo. And I think those are the only
14 dates that, at least to the best of my knowledge, seemed to
15 be reasonable during the month of June.
16 At least one commissioner has indicated the
17 entire month of July is out entirely. And I will try to set
18 something up for that time.
19 In addition to which, I have here -- whether or
20 not for members of the commission who are in fact
21 participating in the commission or not -- my memo. I assume
22 l that everybody did get my memo of May 14?
23 MS. MASON: Memo?
24 MR. GOLDMAN: Did you get my memo?
25 MS. MASON: No.

1 MR. GOLDMAN: Okay.

2 MS. MASON: I might have overlooked it. Has it

3 been a while?

4 MR. GOLDMAN: May 14th.

5 MS. MASON: By Fax, right?

6 MR. GOLDMAN: Yes.

7 MS. MASON: I don't have a Fax machine.

8 MR. GOLDMAN: All right, then you probably

9 haven't gotten it yet, which is a good reason why you haven't

10 responded to it. I have one copy. It's my only copy though.

11 MS. BYRNES: I have extra.

12 MR. GOLDMAN: You have extra? Okay. Attached

13 to that I put together, after speaking to some of the people

14 involved, some ideas. And I have a series of nine questions.

15 And I am going to pass this out and would ask that everyone

16 -- and I am including within that when I say "everyone" --

17 people who have agreed to serve on the committee as well as

18 those who are not, and including staff as well.

19 I would ask everyone if they would do their

20 best to answer or provide some responses to the nine

21 questions that are here, and I would request that all

22 responses be sent to me on or before May 31st of this year.

23 The idea is that when I get them, I will get

24 them collated and put together so that they will be out again

25 and people will have a chance not only to have sent them in

1 but gotten them and gotten a chance to see everybody else's
2 comments prior to any meeting.
3 DR. KONIGSBERG: Don, before you do that, have
4 you any notion where we are going to spend that weekend?
5 MR. GOLDMAN: None at all. Unless you mean
6 citywise? I hope to be able to work with Maureen and with
7 Frank in order to ascertain an appropriate site. And I have
8 not yet had an opportunity to do so.
9 I have had feedback from Diane who suggested
10 that Patterson, New Jersey, would not be an appropriate site.
11 DR. KONIGSBERG: Amen.
12 MR. GOLDMAN: Nor did she — are you leaving,
13 Belinda?
14 MS. MASON: What?
15 MR. GOLDMAN: Are you leaving?
16 MS. MASON: No, I'm just going to the john, if
17 it's all right.
18 MR. GOLDMAN: That's all right. And if you
19 would just pass these, start with Dr. Peterson, Frank? And
20 send them back.
21 MR. DALTON: Don, do you have a Fax number you
22 want us to send this back to you on?
23 MR. GOLDMAN: Sure, my Fax number is Area Code
24 201, 736-7938. If anyone would like to, they are more than
25 happy to send me a disk if it is in Word Perfect format or

1 ASCII format. That would make it even easier to collate your
2 comments.
3 Anyway, my hope is that perhaps before -- you
4 have? And how about one for Belinda? I only made a few
5 copies on my own photocopy machine. If you could pass one
6 down there and maybe someone in staff can reproduce it for
7 the rest of the staff. Would that be okay?
8 And my hope is that getting this information
9 together, we may have a conference call even before then. I
10 will try to work that out and get some times and dates and
11 plan to meet then and see where things go.
12 If anybody has any questions, thoughts or
13 ideas, we welcome them. That's it.
14 June, I am done.
15 DR. OSBORN: You are done, all right.
16 MS. BYRNES: One last thing. I don't feel like
17 I have got closure on the second July meeting. Should we
18 plan to schedule one? I am not sure how you would like for
19 me to handle this.
20 DR. KONIGSBERG: It was 30 and 31?
21 MR. ALLEN: Maureen, it seems to me that we
22 probably ought to plan to spend the time having a chance
23 together to discuss issues in the final report. I mean,
24 without knowing exactly what the reactions are going to be,
25 having seen final drafts, it seems that the process -- every

1 time we do have an opportunity for that clearly reinforces
2 the need for more time like that.
3 So, I would say that it ought to be scheduled
4 if at all possible and it could be canceled if the first
5 meeting goes smoothly and we are all out on time and
6 everyone is happy.
7 MS. BYRNES: I would just like to make a
8 suggestion. I think --
9 MS. DIAZ: We haven't heard a report on where
10 the meeting of the religious task force --
11 MS. BYRNES: Yes, that was the point.
12 MS. DIAZ: And I am just saying that the date
13 seems to be jelling for the 18th. Is the 19th a possibility
14 since there is already four or five commissioners that will
15 be there for the other one and they could be in sequence?
16 MR. KESSLER: I would be there on the 18th.
17 MS. DIAZ: Yes.
18 MR. KESSLER: So, I guess the 19th is --
19 MS. DIAZ: Friday.
20 MR. KESSLER: -- okay for me, I think.
21 MS. DIAZ: Diane will be there on the 18th. I
22 know I will. A number of people will be there for the 18th
23 of July.
24 MS. BYRNES: It sounds like we should schedule
25 July 19th. And if you decide on the 10th and 11th, and we

1 don't need it, we will scratch it.

2 MR. ALLEN: July 19th, one day.

3 DR. OSBORN: Well, at the risk of sounding a

4 little bit like a schoolmarm, there is one thing I would like

5 to bring up. I know we won't very often have meetings that

6 are as packed with witnesses as we had these last two days.

7 But any time we have witnesses, I must confess

8 that it gets extremely uncomfortable in the chair when more

9 than one or two commissioners are out of the room at the same

10 time.

11 And I know everybody has got pressures and are

12 busy. But, quite frankly, there were some times today when I

13 was pretty much by myself up here. And people did in fact

14 comment, some of the witnesses.

15 So, I don't think there is anything more that

16 can be done about it except for commissioners to try and be

17 very sensitive to the fact that somebody else is out of the

18 room and defer if they possibly can defer their departure.

19 I think people will readily understand if any

20 one commissioner gets up and leaves. But in these hearings

21 there were several times when I found myself acutely

22 embarrassed for the commission because people were out in

23 greater numbers than were in.

24 And so, as kind of a wistful request for a

25 favor, sitting in the chair under those circumstances is that

1 much more difficult and I would appreciate it if people would
2 try to be considerably more sensitive to who else is out so
3 that we don't have this mass exodus impression.
4 I know people are doing important things
5 outside. So, I don't misunderstand in that regard. But on
6 the other hand, I know in this set of hearings it did not
7 help us in the overall atmosphere.
8 MS. BYRNES: Are there any other issues or
9 concerns the commissioners want to raise at this time?
10 (No response.)
11 MS. BYRNES: If not, I would like on the record
12 to thank all of the staff for the time and effort and work
13 that goes into all of our activities and hearings, but in
14 particular this one was quite a feat to put together. And I
15 really think it was very, very well done.
16 I think there are always some things we can
17 learn and do a little bit differently the next time, the next
18 time, the next time.
19 But for the time and effort and thoughtfulness
20 that went into putting together yesterday and today and the
21 degree of difficulty planning meetings across the country and
22 really working with communities, many of whom have not worked
23 with the National Commission on AIDS before, and trying to
24 provide lots of different opportunity for different peoples
25 to feel that they have had a chance to share some of their

1 experiences and thoughts, I thought we all did quite a nice
2 job. And I wanted to thank you very much.
3 And we are adjourned.
4 (Whereupon, at 4:00 p.m., the San Francisco
5 Hearing of the National Commission on AIDS was adjourned.)
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1 C E R T I F I C A T E

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3 This is to certify that the attached

4 proceedings before the NATIONAL COMMISSION ON AIDS for the

5 Hearings held May 17, 1991, in San Francisco, California,

6 were held as therein appears, and that this is the

7 original transcript thereof for the files of the

8 Commission.

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12 FRANCES L. RHUDY

13 Official Reporter

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