
A Checklist for Equalizing Relations

Privilege is invisible to those who have it. To create a context which embraces diversity and in which no one is marginalized, a conscious and ongoing effort is required. By noticing and changing what we take for granted, we make room for everyone's contribution. This list is offered as a way to help group members reflect on their own behavior:

- Don't patronize.
- Don't challenge tone, attitude or manner.
- Don't interrupt.
- Don't assume you're more capable.
- Don't assume anyone is more "suited" for anything.
- Don't take responsibility for, think for, or speak for others.
- Don't assume someone is exceptional compared to the "average" person of their group.
- Don't assume an individual speaks for or has the same opinions as others from their group.
- Don't be the only one controlling the organization's resources.
- Don't reduce difficulties to personality conflicts.
- Don't assume the root of a problem is misunderstanding or lack of information.
- Don't ask others to explain, prove, or justify themselves.
- Don't trivialize.
- Don't take up all the space or always speak first.
- Don't ignore or minimize differences by emphasizing similarities.
- Don't overlook history and equate all oppressions as equal.
- Don't expect "others" to educate you about their group's history, conditions or sensibilities.
- Don't expect others to be grateful.
- Don't defend mistakes by focussing on good intentions.
- Don't try to guess what's needed.
- Don't expect to be trusted.
- Don't take everything personally.
- Don't assume everyone has the same options you do.
- Don't assume that the visible reality is the only one.

DO:

- Expect discomfort when relating to people different from yourself.
- Notice what you expect from and assume about others, and note what experiences formed your ideas.
- Name unacknowledged realities, so that the parameters of the situation expand to include everyone's experience.
- Address the many dimensions of accessibility, including such things as money, space, transportation, childcare and language.
- Remember that others speak about more than the conditions of their own group.
- Regard people as whole human beings with families, interests and ideas beyond those of the particular task.
- Take responsibility for equalizing power.
- Name dominating behavior when you see it.
- Encourage pride in your own and other's ancestry and history.
- Understand individuals in the context of their social history.
- Look for political differences rather than personality conflicts.
- Ask questions.
- Struggle over matters of principle and politics.
- Respect disagreements.
- Make accessible all information and let others decide if they are interested.
- Appreciate the risk a person takes in sharing their experience with you.
- Appreciate efforts to point out mistakes. (You must be doing something right, or no one would bother to tell you what's wrong.)
- Take risks.
- Trust others.

In Whatever Ways We've Been Oppressed

In addition to keeping ourselves in check in regarding whatever ways we possess privilege, it is vital that we stop constraining ourselves—*stop* keeping ourselves in check, in the particular ways that relate to how we have experienced being an "outsider." We have to take the risk of *putting our experience into the center*. We can no longer afford to collude with our own oppression by accommodating and/or not acknowledging our own power.

It is also important to remember that offensive behavior is not necessarily calculated to protect power. It is often simply a result of ignorance. Those with privilege have never needed to understand the experience of others.

The above has been excerpted from the pamphlet entitled

Breaking Old Patterns Weaving New Ties: Alliance Building by Margo Adair & Sharon Howell

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Behavioral Patterns that Perpetuate Relations of Domination

An individual from the . . .

Dominant Group

Defines parameters, judges what is appropriate, patronizes.

Assumes responsibility for keeping system on course. Acts unilaterally.

Self-image of superiority, competence, in control, entitled, correct.

Views self as logical, rational. Sees others as too emotional, out of control.

Presumptuous, does not listen, interrupts, raises voice, bullies, threatens violence, becomes violent.

Initiates, manages, plans, projects.

Sees problems and situations in personal terms.

Often needs to verbalize feelings.

Sees solutions to problems as promoting better feelings.

Thinks own view of reality is the only one. Disagreements are result of lack of information, misunderstandings, personalities.

Believes certain kinds of work below their dignity.

Does not acknowledge constraints in current situations.

Regards own culture as civilized, regards other's as underdeveloped, disadvantaged.

Turns to others' culture to enrich humanity while invalidating it by calling it exotic.

Oppressed Group

Feels inappropriate, awkward, doesn't trust own perception, looks to expert for definition.

Blames self for not having capacity to change situation.

Self-image of inferiority, incompetent, being controlled, not entitled, low self esteem.

Often thinks of own feelings as inappropriate and a sign of inadequacy.

Finds it difficult to speak up, timid, tries to please. Holds back anger, resentment, rage.

Lacks initiative, responds, deals, copes, survives.

Sees problems in social context, results of system, "them."

Sees no point in talking about feelings.

Sees solutions to problems in actions that change conditions.

Always aware of at least two views of reality, their own and that of the dominant group.

Believes certain kinds of work beyond their ability.

Sees current situations in terms of past constraints.

Feels own culture devalued, under assault.

Uses cultural forms to influence situation; uses humor, music, poetry, etc. to celebrate collective experience. Sees these forms as being stolen.

The above patterns have been excerpted from the pamphlet entitled
Subjective Side of Politics by Margo Adair & Sharon Howell.

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Definitions used at Atlanta University School of Social Work

White Experience- refers to the series of historical and cultural events of the European people who used an economy built upon the excess profits of the institution of chattel slavery to create a society who's economic and social order is characterized by racism, individualism, exploitation of the natural environment and profit making. Authorities describe the American socio-economic system as being characterized by the three P's of white racism: power, profit and privilege.

Black Experience- refers to the series of historical and cultural events of Black people which began when they were brought to America from Africa as chattel slaves more than 400 years ago. The extraordinary resilience and resourcefulness of the African slave and his/her descendants have enabled them to create viable mechanisms for coping with the dehumanizing character and legacy of slavery to survive as a distinct racial and cultural group despite the oppressive nature of society.

Suggested readings

White experience:

Lillian Smith. Killers of the Dream N.Y. Northern Press 1961

Kovel, Joel. White Racism A Psychohistory N.Y. Pantheon Books, 1970

Black experience:

Billingsley, Andrew. Black Families in White America Englewood Cliffs, N.J., Prentice-Hall, Inc., 1968.

Bennett, Lorone. "The Making of Black America" serialized in Ebony. June 1969; Nov. 1969; Oct. 1970; Nov. 1970; Dec. 1970.

Halpern, Florence. Survival: Black/White N.Y. Pergamon Press, 1973.

Institutional and Ideological

Roots of Racism

Racism is both overt and covert. It takes two, closely related forms: individual whites acting against individual blacks, and acts by the total white community against the black community. We call these individual racism and institutional racism. The first consists of overt acts by individuals, which cause death, injury or the violent destruction of property. This type can be reached by television cameras; it can frequently be observed in the process of commission. The second type is less overt, far more subtle, less identifiable in terms of specific individuals committing the acts. But it is no less destructive of human life. The second type originates in the operation of established and respected forces in the society, and thus receives far less public condemnation than the first type.

STOKELY CARMICHAEL AND CHARLES V. HAMILTON

Negroes in America have been subject to "victimization" in the sense that a system of social relations operates in such a way as to deprive them of a chance to share in the more desirable material and nonmaterial products of a society which is dependent, in part, upon their labor and loyalty. They are "victimized," also, because they do not have the same degree of access which others have to the attributes needed for rising in the general class system—money, education, "contacts," and "know-how."



Gerald Lenoir, executive director of the Black Coalition on AIDS (L) and Bartholomew Casimir, gay activist, in the People of Color Mobilization Against AIDS March and Rally in Oakland April 1st.

AIDS:

The black community fights back

After years of frustration, SF's black health activists are making inroads against AIDS

By Diana Carpenter-Madoshi

EIGHT YEARS into the AIDS epidemic, the myth that AIDS is a gay white male disease continues to thrive in San Francisco's black community, despite increasingly alarming statistics demonstrating the rapid spread of the disease among African Americans.

However, after years of frustration, denial and inaction, the black community is starting to fight back.

The sharp upsurge of AIDS cases among blacks over the past three years has spurred black health professionals, community leaders and even socially conservative ministers to mobilize at a new level. Suddenly, medical, educational and emotional support services are sprouting in a community where a few short years ago people infected with the AIDS virus or at risk of infection had almost nowhere to turn.

It hasn't been easy: Black AIDS activists face a history of cultural denial, a deeply entrenched intolerance towards homosexuality among many religious leaders and a lack of financial support from the private charities and public agencies that have funded the fight against AIDS in other communities.

"We are in a crisis," Larry Saxon, former executive director of the East Bay AIDS Project, told the Bay Guardian. "This is the biggest challenge facing African Americans."

AIDS is affecting blacks in frighteningly disproportionate numbers. According to *California AIDS Update*, a state government publication, nearly a third of reported AIDS cases involve black men, seven out of ten babies born with the virus are black and 58 percent of the reported AIDS cases among women are black or Latino.

Since 1981, according to the San Francisco Department of Public Health, 481 blacks in San Francisco have become infected and by 1991, experts estimate that number will skyrocket to 1,140 — plus an additional 1,276 in the rest of the Bay Area.

On a national level, blacks represent 12 percent of the total population, but constitute 26 percent of the AIDS cases. And in California, new cases of blacks with AIDS continue to outpace other groups.

"I was initially a disbeliever until I started listening to the figures," noted Dr. Patricia Evans, associate medical

director of the San Francisco Department of Public Health AIDS Office.

"But some of us in health care and other related fields came to realize that the disease was going to hit 'us' and it was not going to stay on the East Coast."

In 1986 there were no funds coming out of the San Francisco AIDS office specifically for ethnic minority communities, according to Evans. Black health professionals and other black professionals organized the Black Coalition on AIDS as an "alliance of organizations and individuals" working to fight the spread of AIDS in the black community.

THEY FACED formidable enemies in addition to the disease itself. "Issues of homophobia, poverty, racism, sexism and an overall attitude by black ministers that homosexuality is destroying the black family are some of the reasons why a lot of blacks are not actively involved in the fight against AIDS," explained Gerald Lenoir, executive director of the BCA.

Because, even in San Francisco, homosexuality is not as readily accepted in the black community as it is among whites, some gay blacks have a real fear of ostracism.

"Ethnic minorities do not like to be labeled," said Dr. Evans. "Take a man in jail [even if he has same-sex intercourse] — when he comes out of jail he will tell you 'I'm not gay or bi.' " (Many such men also have female partners — another way AIDS spreads so rapidly.)

That fear of ostracism gets in the way of gay blacks seeking medical care for AIDS. In addition, many blacks are skeptical or suspicious of any program connected with the government. The belief is widespread in the black community that HIV/AIDS is part of a government conspiracy to wipe out the black race.

Sala Udin, executive director of the Multicultural Resource Center, sees AIDS as a central part of an overall black health crisis: "Whether it is covert or overt, AIDS has become genocide to African Americans, spurred on by the availability of drugs in their communities."

Blacks with AIDS tend to wait until they are very sick before they seek treatment — and to die faster than gay white males.

Those who are integrated with the gay community will go to gay clinics. But in some existing AIDS programs, Saxon said, blacks face a lack of sensitivity to their culture. "Every black patient I sent to Shanti would leave," he noted. "Now, however, things there appear to be changing under the leadership of the new director, Eric Rofes."

For gay black males reluctant to be identified as gay, or for non-gay blacks at risk for HIV infection, there have been few facilities in their own community that specialize in AIDS-related illnesses.

In part this is a result of a more general shortage of health care in minority communities. "Racism," said Larry Saxon, "is the single most powerful reason this disease has crept into the black community the way it has," citing the Reagan administration's cutbacks in health and welfare programs.

Before 1986, there was only one program specifically targeted for blacks with AIDS — the Bayview Hunter's Point Foundation Program, under the directorship of Shirley Gross.

Now there are at least a half-dozen, including the AIDS Services programs at the Westside Mental Health Center and the Bayview Hunter's Point Foundation.

In addition to homophobia and the lack of accessible and affordable health services, the slow response of the influential black churches has delayed the black community's fight against AIDS.

"The attitude has been: That's sin, we don't need to deal with it," explained James McCray, pastor of San Francisco's Jones United Methodist Church. "The conservative wing of church officials have seen AIDS as a sexually transmitted disease passed on by a lifestyle not sanctioned by the church."

Liberals, on the other hand, says McCray, have seen it as just another outgrowth of their ministry to give support for the suffering without the moral judgment. McCray and his church members have been active in providing help and spiritual support for people with AIDS for two years.

Whatever their views, however, all churches are increasingly confronting the need for emotional support for blacks with HIV/AIDS, as families have become devastated by the illnesses or loss of a loved one with AIDS.

Recently, more black clergy seem to be responding. Reverend Cecil Williams of Glide Memorial Church has been meeting with African American ministers and asking them for more support and unity.

Williams was also instrumental in getting the ministers to participate, several months ago, in a candlelight march in support of help for people with AIDS.

INTRAVENOUS DRUG abuse, experts say, is the main reason for the sharp increase of AIDS among blacks in the last three years.

"The real challenge in the fight to stop or slow the spread of AIDS is in combating the substance abuse and needle use," said Florence Stroud, deputy director of public health.

"We got a very serious threat with the advent of 'crack' cocaine and other high-risk activities of IV drug users," said Rev. Williams. Crack cocaine has led to more heterosexual cases of AIDS in the black community. In 1986, intravenous drug use among blacks accounted for 8 percent of the AIDS cases. Now that has multiplied to a disturbing 18 percent.

The use of drugs and needles has become deadly especially for black women and their unborn children. A third of black women with AIDS become infected with the HIV virus through sexual intercourse with male IV users. Nearly half contract the virus by using contaminated needles or engaging in "survival sex" (a term coined by health professionals for sex exchanged for money or drugs).

"In the wake of the crack usage in the black community, the increase in the number of women who exchange sex for 'crack' is disturbing," said Pat Norman, director of the Youth Environmental Studies (Y.E.S.), a part of the MidCity Consortium to Combat AIDS. Whether crack or the new, highly addictive "ice" is smoked, snorted or taken intravenously, with less money coming in to hire outreach workers, the fight to stop or slow the spread of HIV/AIDS is becoming more grim, she said.

"The AIDS epidemic is the poverty program of the Reagan and Bush administration. We have to fight among ourselves for money for programs we know would be effective if we had more funding," Norman added.

In addition to Y.E.S., the state-funded MidCity Consortium to Combat AIDS is composed of five other San Francisco agencies: California Prostitutes Education Project (CAL-PEP), Central City Hospitality House, Haight Ashbury Free Medical Clinics, Larkin Street Youth Center and the Urban Health Study.

The heart of the MidCity Consortium is the Community Outreach Workers street-based program. It provides health education, training in AIDS-risk reduction, referrals and social support to intravenous drug users.

The Sexual Partners Integrity Resource Intervention Team also works through community health outreach workers, providing AIDS education to sexual partners of IV-drug users, services for sex workers, safe-sex workshops and more. In both of these programs, the outreach workers go out into the community to reach high-risk people who will not come to them.

At the Sept. 12th San Francisco Health Commission hearing, a heated

debate erupted among AIDS-related health providers (BCA, the MidCity Consortium, etc.) and black ministers, over the proposed needle-exchange program.

"It will give addicts ammunition to further destroy themselves, their families and their communities," Reverend Amos Brown of Third Baptist Church warned the Health Commission.

"But letting them [addicts] spread the HIV virus with contaminated needles, you might as well give them ammunition to wipe out the black community," countered Bartholomew Casimir, coordinator of AIDS outreach for the Black Coalition on AIDS.

In the end, AIDS activists like Brandy Moore of the BCA and the Rafiki (Friend) Service Project, Patricia Evans and Shirley Gross persuaded the commission to approve the needle-exchange program by a vote of 5-1.

Moore pointed out, however, that a needle-exchange program is only one aspect of a total strategy to fight AIDS. The focus must be on prevention through education and on accessible treatment programs. Most AIDS-prevention programs, he said, have not had much success with blacks and other minorities because they often disseminate information in a way that is not culturally relevant and readily accessible.

"Blacks must be involved in their community. It must become a cultural fight against the HIV infection if any prevention and treatment program is to be successful," Moore concluded.

Despite the severity of the crisis, most black experts interviewed for this article said they remained optimistic. Sala Udin of the Multicultural Training Center observed, "There is an old African American saying: 'Behind every blessing is a curse and behind every curse is a blessing.' "

African American HIV/AIDS Resource List

BELOW IS A list (not necessarily complete) of agencies, groups and individuals in San Francisco who provide some form of information and/or care to African Americans living with HIV:

AIDS Education for Youth
Bernie Wagner
1950 Mission St., #6
565-9613

AIDS Education Unit
Bayview Hunters Point Foundation
Tanis Dasher, PHD
6025 Third St.
822-7500 (Education & Support)

AIDS Indigent Services
Michael Fremont-McGuire
55 Mason St.
476-6430

Center for Training
Elise Parker
2229 Lombard St.
931-9359

Edgewood Childcare Center
1801 Vicente
661-8560

Renetia Martin, Associate Director
UCSF-AIDS Health Project
1855 Folsom St., 6th floor
476-6430 (Multiservice)

MidCity Consortium
to Combat AIDS
Pat Norman, Program Director
507 Divisadero St.
922-6135 (Training & Education)

W.J. Brandy Moore, MPA
Office of the Speaker/Assembly
350 McAllister St.

Multicultural AIDS
Resource Center

Greg Harmon, Associate Director
1540 Market St. #320
861-2142
(Education Material & Prevention)

Multi-Cultural Inquiry & Research
Drs. Robert and Mindy Fulllove
6025 Third St.
822-40301

Multi-Cultural Training
Resource Center
Sala Udin, Executive Director
1540 Market St., #320
861-2142

Rosalyn Roddy
San Francisco AIDS Foundation
25 Van Ness Avenue, 3rd floor
864-4376 (Social Work)

Larry Saxon, AIDS Consultant
(Program and Education)
Saxon & Quinn Associates
470 Fillmore St. #2
861-7716

San Francisco Black Coalition
on AIDS
Gerald Lenoir, Executive Director
6025 Third St.
822-2223 553-8197

San Francisco City Clinic
356 7th St.
864-8100 (Testing)

San Francisco General Hospital
AIDS Health Service Project
Bldg. 1, room 202

Westside Community Mental
Health Program
WESTCAP Program
Teri Moore, Director
1153 Oak St.
431-9000

— D. C.-M

AIDS and Minorities

Why is it necessary to address the issue of AIDS in racial and ethnic minorities separately from AIDS in any other population? The fact is that a greater percentage of Blacks and Hispanics are becoming infected with HIV than are Whites in the United States. In this country, according to 1980 census figures, Blacks make up 11.5% of the population. However, they make up a much larger proportion of persons with AIDS: 24%. The same is true for Hispanic people, who constitute only 7% of the nation's population, but make up 14% of people with AIDS. Blacks and Hispanics make up only one-third of people with AIDS; however, AIDS is spreading at a faster rate and to a higher percentage of these population groups than to Whites.

Earlier in the AIDS epidemic, some felt that Asians/Pacific Islanders were immune to HIV because there were few reported cases of AIDS among this population. According to the 1980 census, Asian/Pacific Islanders make up 1.6% of the population in this country. AIDS cases among Asian/PI's constitute 0.6% of all AIDS cases. This number will grow unless the population perceives that AIDS poses a health threat to them and takes the necessary precautions against infection.

The data for AIDS cases among American Indian/Alaskan Natives are underreported because of the difficulty of identifying members of this group when they live or receive medical care or counseling outside a reservation or areas where American Indians live in large groups. We do know that some Native American tribes are represented by a few hundred people or less. Even one infected person in this group could represent a serious threat to the entire group.

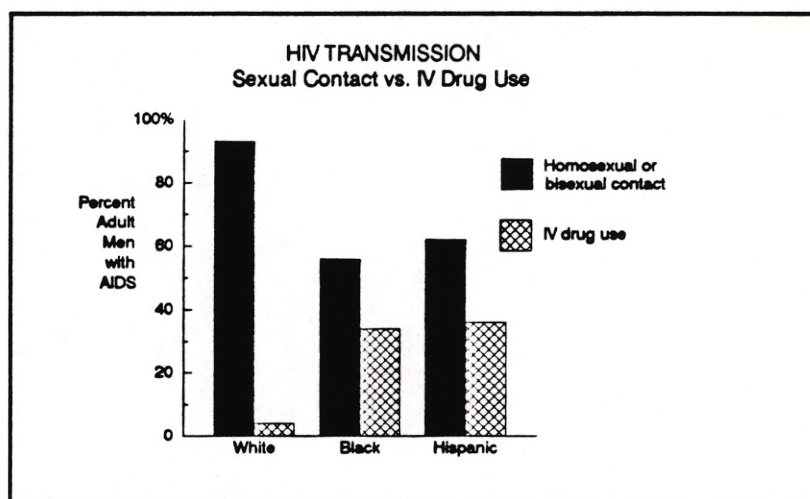
In 1980 American Indians represented less than 1% of the U.S. population. The percentage of all AIDS cases that are American Indian/Alaskan Native is 0.1%. Because of high rates of sexually transmitted disease and substance abuse, American Indians and Alaskan Natives are particularly at risk for HIV infection. The overall number of reported diagnosed cases of AIDS is still low in this population, but growing.

Special emphasis needs to be placed on providing information to these groups about preventing HIV transmission. From research that tells us who and where the people are who are at risk, we will know how and where to focus prevention efforts.

As of May 9, 1988, there were a total of 61,596 cases of AIDS reported in the United States. Over half of those have died of AIDS or AIDS-related causes. It is estimated that there are 1.0 to 1.5 million people in the United States who are infected with HIV. We do not yet know how many of those people will develop AIDS, but observation of a group of homosexual men in San Francisco showed that 48% developed AIDS over a 10-year period.

It is clear from data collected that transmission patterns do vary by race. In White males, HIV is spread mainly by sexual contact between homosexual men; only 4% of White adult men are known to have contracted HIV solely through IV drug use. For Black men with AIDS, however, one-third (34%) were infected through sharing of IV drug needles, and for Hispanic men, 36% became infected through IV drug use (see Figure 1).

Figure 1. Percentage of adult men with AIDS who contracted the virus through homosexual/bisexual contact or through IV drug use.



This figure indicates that a higher percentage of minorities are becoming infected through sharing contaminated IV drug needles than are White men. This may be caused by a higher percentage of Blacks and Hispanics using IV drugs than Whites. Additional factors may also play a role. It may be that needle-sharing practices are more frequent among Blacks and Hispanics than among Whites. It has also been

noted that some IV drug users who are Black or Hispanic tend to have a lower educational level than their White counterparts, and until recently, there were very few funds for outreach into these communities. Therefore, it is possible that Black and Hispanic IV drug users may not know the danger of HIV infection through needle-sharing.

It is clear that the minority drug-using population is as much in need of prevention efforts as are minority homosexual and bisexual men. However, the spread of HIV by male homosexual and bisexual activity continues to be the dominant source of transmission in all adult males, regardless of race or ethnic background, and it is important that these people understand the risk of exposure.

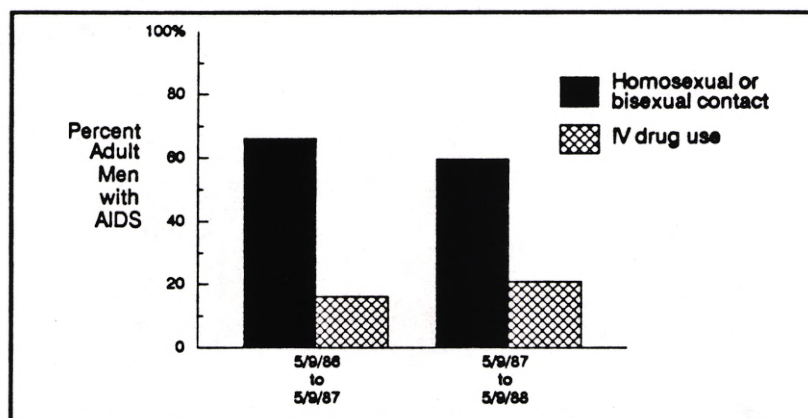
The problems associated with IV drug use and the differences in the social and cultural expression of sexuality, illness and death among minority groups may give some clues as to why AIDS is spreading at a higher rate in some minority groups. The IV drug-using population is difficult to pinpoint and reach with educational programs. Additionally, their behavior usually involves addiction, and therefore is hard to change. They often have complicating physical conditions such as infections (for example, hepatitis B), and access to health care for this group is often difficult.

In addition, attitudes toward homosexuality among the minority groups make it difficult to reach this group with appropriate educational messages. Nearly 60% of Blacks and Hispanics with AIDS were infected through homosexual/bisexual contact (Figure 1). However, definitions or perceptions of homosexuality or bisexuality may differ among these groups. For example, a man who has sex with a man in prison or a man who is in the dominant position may not be considered homosexual.

The White homosexual population has been mobilized and is now a more accessible target for comprehensive AIDS education, and, as a result, several studies suggest that the rate of new HIV infection in that group in some areas is on a steady decline. But this is not so for IV drug using populations or homosexual minority men.

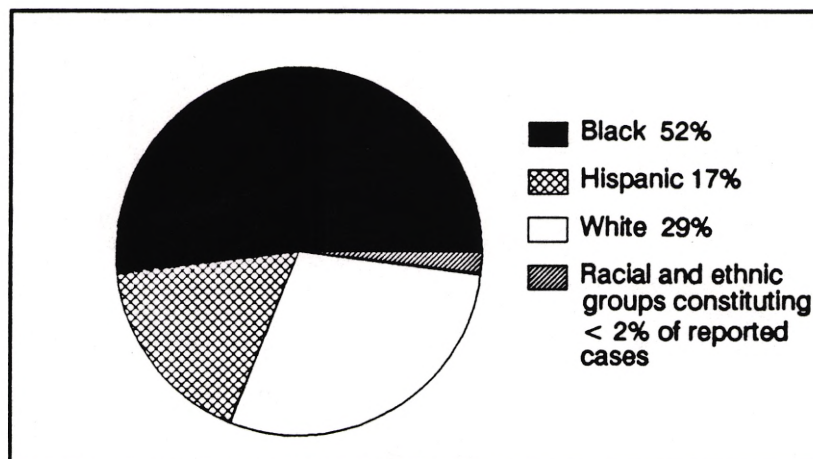
If we compare data from the year May 9, 1986 - May 9, 1987 with May 9, 1987 - May 9, 1988, we can see that the percentage of men with AIDS of all races/ethnic groups who became infected through homosexual or bisexual contact has gone down, while the percentage of men who became infected through IV drug use has gone up (Figure 2). Because we cannot determine exactly when these men became infected, these data indicate trends rather than changes that are specific to a certain time period.

Figure 2. Changes in the percentage of adult men with AIDS contracted through sexual contact or IV drug use.



Because HIV infection in Whites is mainly found in the male homosexual population, it has not spread rapidly to the White heterosexual population. That has not been the case with Blacks and Hispanics, who are more likely than Whites to have become infected with HIV by sharing IV needles. These persons have often transmitted the virus to their heterosexual partners. Since there is a high rate of HIV infection in minority drug users, it follows that there is a high rate of AIDS in their heterosexual partners. Black and Hispanic women account for almost 70% of adult women with AIDS (see Figure 3).

Figure 3. Adult women with AIDS by ethnic background. (as of March 11, 1988).



White women account for only 29%. Over 60% of minority women with AIDS have become infected through sharing contaminated needles. Over 30% became infected through heterosexual contact. Through these infected women, a very high number of minority children are becoming infected during birth.

Over half of the children with AIDS in the United States are Black (Figure 4). Black and Hispanic children together make up 74% of children with AIDS. Most of those minority children were infected in the womb or during birth. White children account for only 23% of children with AIDS, and over half of these children became infected by receiving a contaminated blood transfusion or blood product (Figure 5).

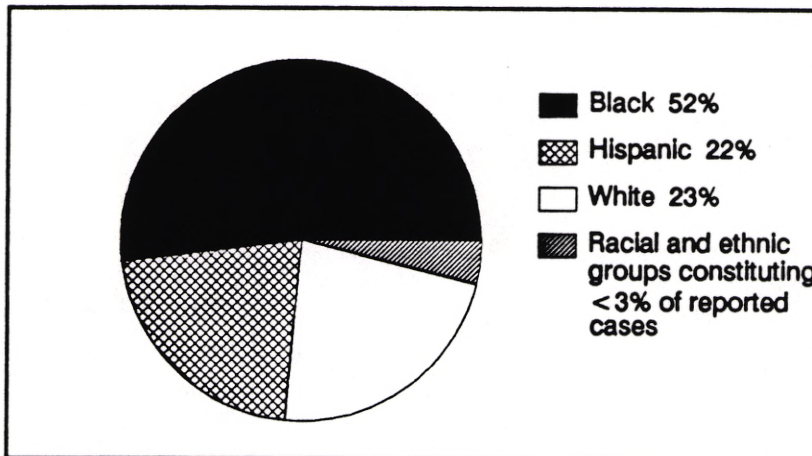


Figure 4. Children with AIDS by ethnic background.

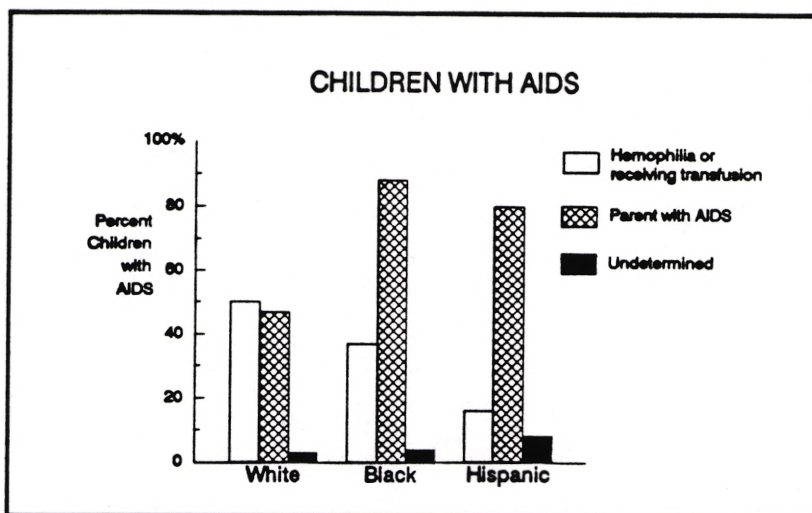


Figure 5. Children with AIDS by ethnic background and risk factors.

Since March 1985, all donated blood in the United States has been screened for HIV, so the rate of new infection by this route has practically reached zero.

It is imperative that all racial and ethnic minorities become involved in understanding the methods of transmission of HIV and the steps to prevent HIV infection and AIDS since there are people who engage in high-risk behavior in these communities.

There is currently no effective cure for AIDS, and there is no vaccine which will prevent infection with HIV. Scientists are working to make headway in both of these areas. There are, however, tests that together or in sequence will confirm whether or not a person is infected with HIV. At present, our only way to prevent the spread of AIDS is through preventing exposure to the virus. All known methods of transmission have been publicized, and the steps to prevent exposure have also been well defined.

1. Individuals should not have sex with infected persons. The more sexual partners a person has, the greater the chance of coming into contact with an infected person. Practicing abstinence or maintaining a relationship with just one person will protect a person from HIV infection, providing that the partner also remains faithful to the relationship and is free from HIV infection. If a person is in a relationship with an infected person, both parties should investigate methods of safer sex through counseling with their physician or an AIDS outreach education counselor. This may involve always using condoms or changing sexual behavior to avoid risky sexual practices.
2. Precautions should be taken to avoid direct contact with infectious fluids such as semen and vaginal secretions during sexual activity with a person whose HIV status is unknown. Use of condoms for 100% of sexual encounters with partners of unknown HIV status will reduce (by 80-90%) the risk of HIV transmission, but will not totally eliminate the risk.
3. Intravenous drug users should not share needles. If needles and syringes are reused, they should be thoroughly disinfected.

4. Women who are at high risk of being infected and who are pregnant or could become pregnant should get testing and counseling for HIV infection.
5. Persons who are HIV-infected or who may have exposed themselves to the virus should not donate blood, body organs, or other body fluids.
6. Infected and uninfected persons should not share razors, toothbrushes, or other items that might cause cuts or be contaminated with blood.
7. Health care workers should always be careful to follow the proper procedures in caring for all patients, whether the patient's HIV status is known or not.

These steps often involve changes in long-established behavior that may be hard to bring about.

The number of people diagnosed with HIV infection each year will continue to increase at least into the next decade. It is estimated that as many as 365,000 persons will have been diagnosed with AIDS in the United States by 1992. It is, therefore, crucial that we be able to identify those groups at risk, prevent new infections, and prepare to provide services to all who are ill.

Bibliography

There are many sources of excellent information on AIDS and HIV infection in general. You can find these sources by contacting

- your local medical society
- a nearby medical school library
- National AIDS Information Clearinghouse:
1-800-458-5231
- National AIDS Hotlines: 1-800-342-AIDS (English);
1-800-344-SIDA (Spanish)

In addition, you may find the following helpful in understanding the problem of AIDS and minorities:

Bakeman R, McCray E, Lumb JR, et al. The incidence of AIDS among Blacks and Hispanics. *Journal of the National Medical Association* 1987;79(9):921-28.

Guinan, ME, Hardy A. Epidemiology of AIDS in women in the United States. *Journal of the American Medical Association* 1987;257(15):2039-2042.

Rogers MF, Williams WW. AIDS in Blacks and Hispanics: implications for prevention. *Issues in Science and Technology* 1987;III(3):89-94.

Schinazi RF, Nahmias AJ. *AIDS in children, adolescents and heterosexual adults: an interdisciplinary approach to prevention*. New York: Elsevier Science Publishing Co., 1988.

For the general population:

Centers for Disease Control. *AIDS: Recommendations and Guidelines, November 1982 - December 1987*. U.S. Government Printing Office: 1988-530-009/64831, April 1988.

Surgeon General's Report on Acquired Immune Deficiency Syndrome (pamphlet available by calling the National AIDS Hotline: 1-800-342-2437 or Spanish language hotline: 1-800-344-SIDA)

Understanding AIDS. HHS Publication No. (CDC) HHS-88-8404. (Available by calling the National AIDS Hotline: 1-800-342-2437. Spanish language version available through the Spanish language hotline: 1-800-344-SIDA)

Definitions of Co-dependence

A primary disease and a disease within every member of an alcoholic family.

Sharon Wegsneider-Cruse

Co-Dependency: An Emerging Issue

Co-dependency is a pattern of learned behaviors, feelings, and beliefs that make life painful.

Sondra Smalley

An emotional, psychological, and behavioral condition that develops as a result of an individual's prolonged exposure to, and practice of, a set of oppressive rules - rules which prevent the open expression of feelings as well as the direct discussion of personal and interpersonal problems.

Robert Subby

Lost in the Shuffle

Ill health, or maladaptive or problematic behavior that is associated with living, working with, or otherwise being close to a person with alcoholism.

Charles Whitfield

Healing the Child Within

Anyone who has been affected by the person who has been afflicted by the disease of chemical dependency.

Earnie Larsen

Stage II Recovery

An underlying, generic, primary disease whose assumptions, beliefs, and lack of spiritual awareness are openly supported by the society in which we live.

Anne Wilson Schaef

Co-Dependence:

Misunderstood-Mistreated

AIDS In San Francisco: New Controversies For The African American Community

By Ahimsa Porter Sumchai, M.D.

The San Francisco Department of Public Health's (DPH) *Status Report on AIDS in San Francisco for Fiscal Year 1987-88* details the current dimensions of the epidemic in San Francisco. The AIDS epidemic is termed "... the most serious health crisis ever faced by the City and County of San Francisco."

Inclusive of socioeconomic factors and for a multiplicity of reasons, being Black in America is a risk factor for development of the acquired immune deficiency syndrome. By January 31, 1988, 4,371 cases of AIDS had been reported to the DPH. Of this number only 235 (6.5 percent) were Black.

While this relatively small number of cases — at first — suggested the African American community was at low risk for the transmission of AIDS, careful scrutiny of the data revealed a disturbing pattern.

In San Francisco, a clear trend toward increasing numbers of African Americans diagnosed with AIDS was documented. In 1984, the total number of Blacks diagnosed with AIDS was 23 or 4.2 percent of the total population infected. In 1987, 103 cases of AIDS were reported among Blacks or eight percent of the total population infected.

Nationally, it is clear there is a disproportionate number of people from racial and ethnic minority groups with AIDS. These statistics differ sharply from the San Francisco experience. By February of 1988, 12,974 cases of AIDS had been reported among Blacks in the United States representing 25 percent of the total population of AIDS cases.

This frightening national trend has given San Francisco a unique protective opportunity. While it is clear that a growing number of AIDS cases arise from the African American community, with aggressive action and public education we are in the position to slow the progress of this epidemic among Blacks in this city.

The heart of the issue rests in understanding that the absolute number of people with AIDS is not a true reflection of the magnitude of this lethal epidemic.

Recall that the time from infection with the AIDS virus to manifestation of disease may be greater than five years. Thus we are looking backwards in time at the infection rate five years ago when we tally the number of AIDS cases today.

By the same token, to accurately gauge the numbers of AIDS cases we will be responsible for caring for five years in the future we must have a reliable sense of the numbers of individuals in the African American community infected with the AIDS virus today—with or without symptoms.

The most important numbers then are the numbers which indicated how many people each year become infected with the AIDS virus, not the absolute number of people with clinically evident disease. It is on the basis of

this information that the true threat of the AIDS epidemic to the Black community becomes most evident.

New studies indicate that for multiple reasons the rate of HIV infection may be ten times higher among Blacks compared to the general population. One study, recently cited by Donald Francis, M.D., head of the Mayor's Task Force on the HIV Epidemic, involved the testing of blood from all babies born in California.

This study is an indirect measure of the rate of infection by the AIDS virus of all women in the state. The rate of infection among the general population was one case per thousand. The rate of infection among Black women was one case per hundred!

There are currently multiple studies in progress to determine the rates of infection in high-risk neighborhoods. The Center for AIDS Prevention Studies (CAPS) has been established to coordinate research studies conducted primarily in minority communities that emphasize education in AIDS prevention.

CAPS is conducting a study of AIDS infection in 1,500 single adults, 20 to 45 years of age in the Western Addition, Mission and Bayview-Hunters Point areas of San Francisco.

Racism and segregation impact the Black community by producing a physical and psychological "quarantine" which contains transmission of infectious diseases within the community, conferring protection upon the outer society. The African American community must recognize that confinement of the spread of AIDS within the Black community is enhanced by the reality of racial segregation.

The role of public education in prevention of AIDS transmission cannot be overemphasized. AIDS prevention programs have been highly successful in the mostly-white gay community by bringing about a change in health-related attitudes and high-risk sexual behaviors.

It is clear that behaviors will change when AIDS is perceived as a true threat to the Black community, when AIDS is recognized as being avoidable and when the Black community collectively supports change in behaviors which lessen disease transmission.

Such a successful community program had dramatic impact on control of hypertension among Black men in Baltimore, Maryland.

The most complex issue we are now faced with is the potentially explosive spread of AIDS among IV drug users and its impact on the heterosexual community. IV drug users are perceived as a politically powerless group offering a much greater challenge to change in high-risk behavior than was seen among gay men.

The Black community is disproportionately represented among the IV drug-using population and the need for responsible leadership in addressing strategies to reduce the impact of the AIDS epidemic on Black

heterosexuals via this route of infection is mandated.

Responsible leadership is also needed in an effort to reduce AIDS hysteria. A recent public opinion poll revealed that one out of four people in the Bay Area fears AIDS. While this fear is effective in bringing about desirable changes in high risk behaviors it has also worked to instill negative attitudes among the general public and health care professionals about AIDS victims.

These attitudes, coupled with racist perceptions, may have destructive impact on Black AIDS victims from a community traditionally underserved by health care resources.

The final controversy we are left to contend with is the new direction of therapy for victims of asymptomatic AIDS infection called Early Intervention and Care. There is increasing evidence that two new drugs may prevent or delay the progression of disease among persons who have tested HIV positive, but have no symptoms of AIDS.

This preventive treatment may prolong life, decrease hospitalization and overall medical costs. The thrust for early intervention and care has formed the strongest justification for mass testing for HIV status.

For the first time, the potential for preventing the development of AIDS has prompted campaigns encouraging gay and bisexual men, IV drug users and their sexual partners to learn their HIV status.

While this hope for improved outcome is the "brightest star" on the horizon of AIDS research, it is estimated that there are approximately 30,000 people in San Francisco who are HIV positive and in need of testing, evaluation and early therapy.

The cost for providing care for all HIV-infected individuals in San Francisco will be in the range of \$100 million per year. The majority of the cost will go toward the purchase of drugs.

One such drug, AZT, or azidothymidine, has been shown by the National Institute of Allergy and Infectious Diseases trial to benefit persons infected with the AIDS virus who have not yet developed symptoms. AZT therapy is now estimated to cost each patient \$4,600 per year.

Another recommended drug which is believed to reduce the risk of pneumocystis carinii pneumonia is aerosolized pentamidine. Its use will cost \$1,200 per year.

The reality of delivering high-cost medications and expensive care to persons lacking health care insurance must be faced. The task of providing therapy to uncompliant intravenous drug users must be addressed.

Government subsidy for the burden of health care costs of AIDS victims is mandatory. For advocates of socialized medicine in the United States, the human and monetary costs of the AIDS epidemic factors may revolutionize the very foundation of our health care system.

**Congreso internacional sobre
la problemática social del SIDA**

**HIEsen gizarte arazoei buruzko
nazioarteko biltzarra**

10, 11 y 12 de Diciembre de 1990.
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SOCIEDAD

Presentación

El SIDA, al que algunos han denominado «azote del siglo XX», ha traído consigo, además de muertes, un cambio importante en los comportamientos sociales.

La escasa información suministrada a los ciudadanos, motivada sin duda por la complejidad de la enfermedad y la variopinta leyenda que ha acompañado a cuantas interpretaciones se han dado relativas a la forma de contraer el SIDA, y el fatal desenlace al que conduce la enfermedad, han movido automáticamente a los ciudadanos a aceptar comportamientos preventivos, no siempre idóneos, basados más en la oscura leyenda que en el rigor científico. Han sido comportamientos caracterizados, en la mayoría de los casos, por el miedo y la ignorancia.

Sin embargo se ha dado, al menos para mí, un comportamiento social no preventivo, mucho más preocupante: la sociedad, en su conjunto, no sólo ha rechazado al SIDA sino principalmente a quienes lo padecen, creando de este modo una nueva y peligrosa forma de marginación. Así pues, a la complejidad científica y médica se debe añadir la complejidad social.

A sabiendas de que investigadores y científicos trabajan denodadamente en resolver las incógnitas médicas, debemos desde los Departamentos de Bienestar Social abordar esa dimensión social procurando llegar a soluciones prácticas que permitan prestar asistencia a los marginados por dicha causa y sensibilizar a los «causantes» de su marginación para que llegue un momento en que no se produzca más.

Este congreso ha de ser un instrumento importante para lograr ambos fines y, sobre todo, para que quienes estamos llamados a abordar desde las instituciones y Asociaciones el problema de los afectados de SIDA, nos pongamos de acuerdo en el mejor camino a seguir.

Josu Montalbán Goicoechea

Diputado Foral del Departamento de Bienestar Social

Aurkezpena

Batzuk XX. mendeko zigorra deitu duten HIES-ak, heriotzeak ekartzeaz gainera, aldaketa garrantzitsua sortu du gizartearen jokabideetan.

Hiritarrei, gaisotasunak dituen zailtasunak eta HIES-az kutsatzeko erari buruzko esames ugariak direla bide, eman izan zaizkien informazio urriak edo eta gaisotasunak ekarri ohi duen olabeharrezko azkenak, zientziaren zehaztasunean baino gehiago esames ilunetan oinarritutako alde zurretiko jokabideak, ez beti egokiak, automatikoki onartzeraz eraman ohi dituzte hiritarrak.

Hale eta guztiz ere, nire eritziz, izan da, kezkarria goa den aurretiazko ardurarik gabeko gizarte-jokabiderik ere: hain zuzen ere, gizarteak, orokorrean, bere ukoa HIES-ari egiteaz gainera, halakudien ondorioak jasaten dituztenei ere egitea, horrela marginazio-era berri eta arriskutsua sortuz. Beraz, zientzia eta medikuntza alorreko zailtasunari gizarte alorrekoa erantsi behar zaio.

Ikertzaile eta zientzialariek, etengabeki, medikuntza alorreko ozkutukoak argitu nahiean dihardutela jakinez, Gizarte Ongizate Sail honek gizarte-alor horri ekin behar dio, halakoaren zioz baztertutakoei laguntza ematea eta delako marginazioaren «eragileak», aurrerantzean halakorik gerta ez dadin, sentiberatzea ahalbideratuz, irtenbide praktikoak lortzeko.

Biltzarre hau, bi helburu horiek lortzeko eta, batez ere, Erakunde eta Elkarrekin HIES-ak ukiturikoan egoerari aurre egitera deituak garenok jarraibiderik onena bilatzera bultzatzeko baliabide garrantzitsua izan behar du.

Josu Montalbán Goicoechea

Ogasun Gizarte Sailaren Titularea

Secretaría técnica
Idazkaritza teknikua

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Miércoles, 12 de Diciembre

Martes, 11 de Diciembre

Lunes, 10 de Diciembre

Ficha de inscripción

Nombre

Apellidos

Empresa

Cargo

Idiomas

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09,30/10,30

Recepción de asistentes y entrega de material

10,30/11,30

Inauguración del Congreso por el Ilmo. Sr. Diputado Foral de Bienestar Social. D. Josu Montalbán Goicoechea

11,30/12,00

Pausa - café

Presentador de las Ponencias: D. Angel Martínez

12,00/12,45

«Proyección sociológica de los avances biomédicos del SIDA»

Ponente: Dr. D. Rafael Najera Morrondo

Director del Instituto de Salud Pública Carlos III. Madrid

12,45/13,15

Ruegos y preguntas

Presentador y Moderador de las Ponencias: D. José Ignacio Berriatua

16,30/17,15

«Plan de actuación de la Diputación Foral de Bizkaia en la problemática del SIDA. La casa de acogida Bi-Etxeak»

Ponentes: D. Josu Montalbán Goicoechea

Diputado de Bienestar Social de la Diputación Foral de Bizkaia

Sor Nieves Díaz Corres

Directora de la Casa de Acogida para afectados de SIDA «Bi-Etxeak» de Bilbao

17,15/17,45

Ruegos y preguntas

17,45/18,15

Pausa - café

18,15/19,00

Mesa redonda

«SIDA y servicios sociales»

Participantes: Representantes de las Casas de Acogida para afectados de SIDA de Madrid, Valencia y Zaragoza

19,00/19,30

Ruegos y preguntas

20,00 horas

Recepción oficial en el Palacio de la Diputación Foral de Bizkaia

09,30/10,30

Etorleei harrera eta langaien banaketa

10,30/11,30

Biltzarrari hasiera ematea: Josu Montalban Goicoechea, Gizarte Ongizateko Foru Diputatu Jn. Tx. Argiak

11,30/12,00

Atsedena - kafea

Txostenetako Aurkeslea: D. Angel Martinez

12,00/12,45

«HIES-ari buruzko aurrerapen bio-medikoen hedakuntza soziologikoa»

Txostenemailea: Rafael Najera Morrondo Dre. Jna. Madrid-eko «Carlos III.a» deritzan Osasun Publikorako Institutuko Zuzendaria

12,45/13,15

Erreguak eta galderak

Txostenetako Aurkeslea y Moderatzailea: D. Jose Ignacio Berriatua

16,30/17,15

«Bizkaiko Foru Aldundiak HIES arazoaren aurrean duen iharduketa plana. Bi-Etxeak deritzan harrera-etxea»

Txostenemaileak: Josu Montalban Goikoetxea Jna. Bizkaiko Foru Aldundiko Gizarte Ongizate Saileko Diputatu

Nieves Diaz Corres Serora

Bilboko «Bi-Etxeak» deritzaneko HIES-ak ukiturikoentzako Harrera-Etxeko Zuzendaria

17,15/17,45

Erregu eta galderak

17,45/18,15

Atsedena eta kafea

18,15/19,00

Mahaingurua

«HIES-a eta gizarte zerbitzuak»

Parteartzaileak: HIES-ak ukiturikoentzako Madrid, Valentzia eta Zaragoza-ko Harrera-etxeetako ordezkariak

19,00/19,30

Erregu eta galderak

20,00 horas

Harrera ofiziala Bizkaiko Foru Aldundiaren Jauregian

Presentador de las ponencias: D. Iñaki Orrantia

09,00/09,45

«Realidad actual del SIDA en España»

Ponente: D. Rafael de Andrés Medina

Secretario General del Plan Nacional sobre el SIDA

Ministerio de Sanidad y Consumo

09,45/10,15

Ruegos y preguntas

10,15/11,00

«Respuestas conductuales y sociales de la población toxicómana ante la amenaza del SIDA»

Ponente: D. Samuel R. Friedman

Investigador Principal sobre Sida de la Compañía de Investigación de Narcóticos y Drogas. EE.UU.

11,00/11,30

Ruegos y preguntas

11,30/12,00

Pausa - café

12,00/12,45

«SIDA y marginación»

Ponente: D. Francisco Monteserín González

Delegado del área de infancia y juventud de Cáritas. Madrid

12,45/13,15

Ruegos y preguntas

15,00/16,30

Visita opcional a la Casa de Acogida para afectados del SIDA Bi-Etxeak

Presentador y moderador de las ponencias: D. Iñigo Pombo

16,30/17,15

«Análisis de la realidad del SIDA en la Comunidad Autónoma Vasca»

Ponente: D. Daniel Zulaika Aristi

Coordinador del Plan de Prevención y Control del SIDA en la Comunidad Autónoma Vasca

17,15/17,45

Ruegos y preguntas

17,45/18,15

Pausa - café

18,15/19,00

Mesa redonda

«SIDA, movimiento ciudadano y grupos de autoapoyo»

Participantes: Representantes de Comisión Ciudadana Anti SIDA de Bizkaia, Askabide y Proyecto Hombre

19,00/19,30

Ruegos y preguntas

Txostenetako Aurkezlea: D. Iñaki Orrantia

09,00/09,45

«HIES-aren gaur egungo egoera espainian»

Txostenemailea: Rafael de Andrés Medina Jna.

Osasun eta Kontsumo Ministeritzako HIES-ari buruzko Estatuko Planaren Idazkari Nagusia

09,45/10,15

Erregu eta galderak

10,15/11,00

«HIES-aren mehatxuaren aurrean toxikomandek dituzten portaera eta gizarte erantzunak»

Txostenemailea: Samuel R. Friedman Jna.

AEB-eko Narkotrafiko eta Drogen Ikerlanetarako Bazkuneko HIES-ari buruzko ikertzaile nagusia.

11,00/11,30

Erregu eta galderak

11,30/12,00

Atsedaldia eta kafea

12,00/12,45

«HIES-a eta marginazioa»

Txostenemailea: Francisco Monteserín González

Madrid-eko Karitas-eko haurtzaro eta gaztaro arloko ordezkaria

12,45/13,15

Erreguak eta galderak

15,00/16,30

Aukerazko ikustaldia «Bi-etxeak» deritzaneko HIES-ak ukiturikoentzako Harrera-Etxera

Txostenetako Aurkezlea eta moderatzailea: D. Iñigo Pombo

16,30/17,15

«HIES-ak Euskal Autonomi Elkartean duen egoeraren azterketa»

Txostenemailea: Daniel Zulaika Aristi Jna.

HIES-aren Aurrearreta eta Kontrol Planaren Koordinatzailea Euskal Autonomia Elkartean

17,15/17,45

Erregu eta galderak

17,45/18,15

Atsedaldia eta kafea

18,15/19,00

Mahaingurua

«HIES-a, hiritar mugimendua eta autolaguntza taldeak»

Parteartzaileak: Bizkaiko Ehies-Aren aurkako Batzordea, Gizakia Helburu eta Askabide

19,00/19,30

Erregu eta galderak

Presentador de las ponencias: D. Luis Rodríguez

09,00/09,45

«Planes de actuación sobre los problemas sociales del SIDA. La experiencia de Amsterdam»

Ponente: Dña. Annette D. Verster

Coordinadora del SIDA en Amsterdam

Departamento de Salud Pública y Medio Ambiente. Holanda

09,45/10,15

Ruegos y preguntas

10,15/11,00

«SIDA: estigmatización y anomía. Análisis de la opinión pública española»

Ponente: D. Ricardo Usieto Atondo

Director del Centro de Estudios Sociales Aplicados (C.E.S.A.). Madrid

11,00/11,30

Ruegos y preguntas

11,30/12,00

Pausa - café

12,00/12,45

«SIDA y derechos humanos»

Ponente: D. Héctor Anabitarte Rivas

Secretario General de la Fundación Anti-SIDA de España (F.A.S.E.)

12,45/13,15

Ruegos y preguntas

13,15 horas

Clausura por la Excm. Ministra de Asuntos Sociales

Dña. Matilde Fernández

14,00 horas

Almuerzo final del Congreso

Txostenetako aurlezlea: D. Luis Rodriguez

09,00/09,45

«HIES-aren gizarte arazoei buruzko iharduketa planak. Amsterdam-eko eskarmentua»

Txostenemailea: Annette D. Verster Andrea

Amsterdam-eko HIES arazoaren koordinatzailea. Holandako Osasun Publiko eta Ingurugiro Sailekoa

09,45/10,15

Erregu eta galderak

10,15/11,00

«HIES-a: estigmatizazioa eta anomia. Espainiako herritarren erizpidearen azkerketa»

Txostenemailea: Ricardo Usieto Atondo Jna.

Madrid-eko Gizarte Azterlan Aplikatuaren Zentruko (G.A.A.Z.) Zuzendaria.

11,00/11,30

Erregu eta galderak

11,30/12,00

Atsedena eta kafea

12,00/12,45

«HIES-a eta giza eskubideak»

Txostenemailea: Héctor Anabitarte Rivas Jna.

Espainian dagoen HIES-aren aurkako Ezarkundeko Idazkari Nagusia

12,45/13,15

Erregu eta galderak

13,15etan

Matilde Fernandez, Gizarte Arazoetarako Ministari Andere Tx. Gorenak bukaera ematea

14,00etan

Biltzarreko azken bazkaria

Presidente:

D. Angel Martínez Flórez

Director General de Servicios Centrales del Dpto. de Bienestar Social de la Diputación Foral de Bizkaia

Vicepresidentes:

Dña. Ana Aizpitarte Palacios

Jefe de la Sección de Grupos de Atención Especial del Dpto. de Bienestar Social de la Diputación Foral de Bizkaia

D. Iñigo Pombo Ortiz de Artiñano

Gerente del Instituto Foral de Asistencia Social

Vocales:

Sor Nieves Díaz Corres

Directora de la Casa de Acogida para afectados de SIDA Bi-Etxeak

Dña. Teresa Herrero Zubiaur

Jefe de la Sección de Relaciones del Dpto. de Bienestar Social de la Diputación Foral de Bizkaia

Dña. Maite Amatria Cuesta

Socióloga del Dpto. de Bienestar Social de la Diputación Foral de Bizkaia

Dña. Miren García Cangas

Trabajadora Social del Dpto. de Bienestar Social de la Diputación Foral de Bizkaia

Secretaria:

Dña. Marina Merino Herrero

Dpto. de Bienestar Social de la Diputación Foral de Bizkaia

Batzordeburua:

Angel Martinez Florez Jna.

Bizkaiko Foru Aldundiko Gizarte Ongizate Saileko Zerbitzu Orokorren Zuzendari Nagusia

Batzordeburuordeak:

Ana Aizpitarte Palacios Andrea

Bizkaiko Foru Aldundiko Gizarte Ongizate Saileko Arreta Bereziko Taldeen Sailatalburua

Iñigo Pombo Ortiz de Artiñano Jna.

Gizarte Urgazpenerako Foru Institutuko Burua

Batzordekideak:

Nieves Diaz Corres Serora

«Bi-Etxeak» deritzaneko HIES-ak ukiturikoentzako Harrera-Etxeko Zuzendaria

Teresa Herrero Zubiaur Andrea

Bizkaiko Foru Aldundiko Gizarte Ongizate Saileko Harreman Sailatal Burua

Maite Amatria Cuesta Andrea

Bizkaiko Foru Aldundiko Gizarte Ongizate Saileko Soziologoa

Miren García Cangas Andrea

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Idazkaria:

Marina Merino Herrero Andrea

Bizkaiko Foru Aldundiko Gizarte Ongizate Sailekoa



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