PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC

HEARING ON PREVENTION AND EDUCATION

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P R O C E E D I N G S

MS. GAULT: Ladies and Gentlemen, Distinguished guests, Members of the President's Commission, my name is Polly Gault. I serve as the designated federal official and inn that capacity it is my privilege to declare this meeting open. Chairman Watkins.

CHAIRMAN WATKINS: Good morning. Yesterday, we heard testimony regarding prevention efforts of the public health system to stem further spread of HIV infection. Eighteen witnesses came before us and gave detailed descriptions of how the various pieces of that system fit together. We heard witnesses from federal, state and local governments who explained how the HIV epidemic has impacted upon their organizations and what they are going to do to meet imposed demands.

Today we will hear testimony on various educational strategies that have potential to be primary preventive tools in the war against the virus. It is important that when we hear the word education we do not only associate it with a formal setting such as the classroom. HIV related education needs to take place at all levels of society in all locations both within and without society's main stream. Today, we will focus our attention on the education of hard-to-reach youth and minorities as well as the educational efforts of community based organizations. Additionally, we will look at the role the media can play in helping to educate various populations within our society.

I am pleased this morning to introduce our first panel of talent, Dr. June Osborn, Dean, School of Public Health, University of Michigan; Paula Van Ness, Director, AIDS Information/Education Program, Centers for Disease Control; and Lynne Mulder, Program Manager, Health Promotion and Education, Florida Department of Health and Rehabilitative Services. A welcome to the Commission and I would like to start with Dr. Osborn for the first statement.

DR. OSBORN: Thank you, Admiral Watkins. It is a pleasure to be here.

Education as a means of preventing transmission of the Human Immunodeficiency Virus is the only effective weapon we have to contain the AIDS epidemic, and it is likely to remain so for several years to come as drugs and vaccines present almost an insuperable biological problems in their creation and development. Given the awesome scope of the AIDS epidemic to date, the need to rely solely on educational preventive strategies sounds worrisome but our science has given us a firm foundation of data to understand the way the virus spreads, and the merciful facts are that the modes of spread are extremely limited. We are fortunate to live in a society where the blood

supply was under excellent regulatory control when the epidemic surfaced so that that involuntary route of transmission could be closed off quickly once the virus was discovered. We are left with sexual intercourse and drug abuse with the sharing of injection apparatus as the major pathways to the epidemic's future.

The good news is that for the first time in human history, individuals can avoid participation in an epidemic by informed personal decision making. That was never an option with polio or yellow fever. You could not amend your behavior on the basis of knowledge and thereby sidestep contagion but you can with AIDS, and that is a marvelous opportunity. In fact, no vaccine will ever be as good as that. But that knowledge carries with it an urgent duty to warn, to convey to people that there is a new deadly virus out there that must be factored into their decisions about sexual behavior and numbers of partners and illicit drug use. The urgency is especially great for adolescents and for children for if they lose in the HIV version of Russian roulette while experimenting with lifestyles they may later reject, the deadly AIDS bullet may take seven or eight or ten years to strike.

There are several levels of educational effort to be discussed. The first and most germane to federal policy and initiatives is aimed at the public at large, a national educational campaign. There is no need for people to be fearful if their personal behavior does not put them at risk. If they knew and fully understood that; our tasks in coping with the epidemic would be vastly easier for we are draining precious energies right now trying to contain or react to public panic and our social values are seriously threatened by a lack of compassion in the society's response to the epidemic to date. I think there are no more incompatible human emotions that personal fear and compassion and since we will have unlimited need for the latter in the days ahead, we must educate the public to alleviate and eliminate irrational fear.

Second, we must tailor our educational message at the community level, refining it to capture the special attention of those who especially need to hear it, those whose behavior puts them at risk. And finally, we must find ways to penetrate the finest subdivisions and subcultures of our communities, employing the language of our intended listeners and enlisting the aid of their peers to be sure that we have communicated our warnings effectively.

It is common practice to invoke a military metaphor when discussing AIDS policy. I think that is useful to the extent that it conveys the urgency of the mortal social problem. Surely the destructive power of the AIDS virus has already earned it a place high on the list of 20th Century killers of youth.

Soon there will be more American cases of AIDS, dead and dying, than there were total deaths in the Vietnam War. But there is a hazard in the military metaphor, for people are inclined to equate all-out response with high technology and the invocation of education as a primary strategic response sometimes seems puny compared to a variety of mandatory testing alternatives.

The essence of that war time analogy, however, is that we must mobilize maximally whatever will work best, and when that operational criterion is applied, then education is our most powerful weapon and words are our ammunition. We must be clever in their deployment. Just as there is no need to offend the public at large in achieving a general level of information, there is no sense in speaking to subcultures in a language they cannot understand. Education for prevention of further spread of HIV has been the first and dominant response of every other industrialized country in the world. We are very late at mobilizing fully in this regard, and we must hurry to embrace the task with a true sense of urgency. Thank you.

CHAIRMAN WATKINS: Thank you very much, Dr. Osborn. Ms. Van Ness?

MS. VAN NESS: Good morning. My name is Paula Van Ness, Director of the Centers for Disease Control's National AIDS Information and Education Program. Next month marks my first anniversary with CDC and prior to that, I led one of the nation's largest service and education organizations focusing on AIDS, AIDS project, Los Angeles. I would like to spend my brief time here with you sharing some key insights that I have gained on the local level as well as the federal level and I hope that will address some of your more pressing concerns.

First, what does the public really know about AIDS? Over 95 percent of all segments of the general public can tell you that AIDS is primarily a sexually transmitted disease and a disease you get by sharing needles. Yet, the public has thousands of unanswered questions. Each day the National AIDS Information Hotline and local community organizations answer over 10,000 calls from the general public. Among the most frequently asked questions are how exactly is AIDS spread during sex, do I need to get tested, will a test tell me anything, are condoms effective, is the blood supply safe, and can I get AIDS from mosquitoes, sweat, toilet seats, shaking hands, contact sports, mouth-to-mouth resuscitation. We as a nation have a long way to go to get very specific answers to questions like these to our general public.

Now I want to focus on a second issue. Are people accurately evaluating their own person risk? The answer to that question today is no. Information collected from interactions with more than 288 community based organizations has told us that

fear of casual contact is pronounced in minority communities and among the young. While many Americans know the facts about AIDS, they do not believe they know enough or they doubt the credibility of the information sources on the subject.

Denial is still a major problem among blacks and Hispanics believing that AIDS is still a white, gay disease, and there is even denial among gay men. For instance, in one CDC focus group held with gay men in St. Louis last fall, many said unprotected anal intercourse is still a social norm in their community, and even in cities like San Francisco and New York where aggressive information and education programs have been instituted, the federal government has a role to play in reinforcing individuals' commitments to practice lower risk behavior. Furthermore, we cannot assume that the gay male population in this country has been educated, and that our attention is better placed elsewhere.

Next issue. Is the government's job done if it can get all the facts out to those at risk? At the World Health Organization's AIDS Summit in London recently, the Danish representative warned her international colleagues that information is not education. Achieving behavior change is a long and difficult process. Those who have worked to change smoking behavior in the United States know that knowledge of the danger alone does not change behavior. Catchy slogans, slick advertising packages cannot be depended upon in and of themselves to promote behavior change. Nor can the one million brochures sent out each week from the National Clearinghouse do the job. A comprehensive program is required.

San Francisco has shown us that effective education programs require a community-wide commitment, a community-wide involvement, the use of a variety of communication channels, political leadership and a community-endorsed social norm that is realistic and effective. That is a tough laundry list, but San Francisco has also shown us that it can be done. The goal is to institute this type of comprehensive approach in cities nationwide.

Next, the fourth issue. Has the Federal Government done enough? The quick answer is no. A related question, has it done a lot? The answer is yes. Since 1983, the Federal Government has been funding state and local health departments and community-based AIDS education programs nationwide. In October of last year, the Federal Government's America Responds to AIDS campaign was launched. It is currently the nation's second most aired public service campaign, second only to partnership for a drug-free America.

Public service announcements that discuss condoms, better communications among sexual partners, AIDS incidence in

the Hispanic community, community action in the black community, and the subject of abstinence are now running nationwide. Total donated television time for the campaign's first three months totals over $4 million. The campaign has also produced special television programs and symposia for physicians and black as well as leadership forums for blacks, Hispanics, Asians, gays, health and youth organizations, religious broadcasters and minority women. The CDC has also cosponsored AIDS education efforts with colleges, corporations, state governments, local governments, non-profit and community-based organizations.

As a result of the campaign, calls to the National AIDS Information line have tripled, and the Federal Government is now servicing over 68,000 calls per month. We are now in the process of preparing a national mailing that will go to every home in America with frank and open discussions about casual contact, sexual and drug related transmission of the virus and AIDS prevention.

An important fifth issue, is anything working? Our campaign is taking place in an environment where there are hundreds of voices speaking daily to the public about AIDS, often with contradictory messages. The news media, the religious community, AIDS service organizations, and even the medical experts are not in agreement on who is at risk, what constitutes risky behavior and what prevention behavior we as a nation should pursue. Determining cause and effect or even obtaining an agreement on what the desired result should be has been elusive.

Unfortunately, we are also doing our job without the best possible measurement of success or failure, an accurate estimate of how fast the virus is spreading. Some city-specific studies have been completed and some national data indicate that behavior may be changing. People are reporting fewer sexual partners, condom sales are up, yet at the same time, CDC is reporting record rates of sexually transmitted diseases and we are finding that information on sexual practices and IV drug use is hard to come by.

I am not a medical expert, but my experience tells me that if we had the necessary data, we would find large segments of the population that are not taking necessary AIDS prevention measures, and that is something we cannot afford to ignore.

A final issue, where do we go from here? We must work to clear up misconceptions about casual contact among all segments of the population but more importantly, we must double our efforts to reach the hardest to reach with AIDS prevention information: IV drug users and their sexual partners, many of them members of ethnic minority groups, bisexual and homosexual men that live in the closet as well as men living in the gay community who are not protecting themselves; teenagers that are

on the verge of experimentation or are already involved in sex and IV drugs; and parents, the primary sex educators for their children and those who have a powerful influence on our social norms; and all Americans whose behavior places them at risk of contracting the AIDS virus.

I promised to share some of my thoughts, but I also want to leave you with some questions. First, what should the federal role be in setting social norms for sexual behavior? Can the government go beyond listing options? Must all communications list a litany of alternatives that start with abstinence and end with condoms?

Second, if the government cannot endorse a behavior, should it restrict the activities of state governments, local governments, or local organizations that do? Third, what criteria would the Commission use to evaluate an effective AIDS information and education program? And, finally, what long term communication strategies would the Commission support in order to influence changes in very personal sexual and drug use behaviors?

I believe your answers to these questions will provide critical direction to our efforts. Thank you.

CHAIRMAN WATKINS: Thank you very much, Ms. Van Ness. Ms. Mulder?

MS. MULDER: Thank you. You asked me to explain some of my ideas as far as barriers to effective education. I believe the Federal Government has a significant opportunity to encourage, to require, issues that facilitate educational efforts now and in the future. First, we must require educational program directors to be qualified and credentialed health educators from quality training programs. This means that we may have to identify which are quality training programs, but if we believe that education is the key to prevention, we may have to reexamine some of our priorities and untie some of the purse strings in order to recruit top level professionals. We cannot afford for public health to be the training ground any longer for our top level professionals and then allow them to get away from us and go to private business and private companies.

Second, we need to require professional education for health care and other professionals so that quality, factual and consistent information is available in every single community. We must educate the media at the same time, and we must work closely with them to make sure that facts are being presented. This should occur prior to any kind of massive educational campaign. If we do it second to that, we will get questions from the public that will not be appropriately answered.

Third, we must require educational programs to produce. We must require realistic goals and objectives and those goals and objectives must answer some questions. They must answer what are the problems, why are they a problem, how are we going to deal with those problems, who is going to deal with them, and what are the results that we want to see at the end? We cannot require behavior change in 15 minutes or less and we cannot look at programs that say they are going to do that and believe that they are providing us with something realistic. It has to do more than just sound good.

Fourth, we must require comprehensive school health education. Local involvement among teachers, students and parent groups, along with Boards of Education and Superintendents is necessary and required. The comprehensive school education must include decision making, values clarification, life style habits and family life education, and all of this must be incorporated along with other health issues if we intend to capitalize on our opportunity to reach the youth in these important years.

Five, we must require networking and collaborative efforts. We cannot pour money into separate agencies and organizations without requiring evidence that they are working with others who have the same or related goals. They must also eliminate unnecessary duplication and use their dollars more appropriately to focus on related issues. They should diversify and do more with less rather than duplicate unnecessarily. They must form local coalitions that give them access to people with diverse backgrounds. They must avoid creation of new jobs and new programs until they have appropriately integrated what we already have and they must involve target groups in what they are doing in order to reach each individual group and the general public appropriately. This networking effort must go beyond the traditional letters of support. Work plans must document this effort. Money is not always the answer.

Six, we must avoid a crisis orientation, a comprehensive integrated approach between public health and community agencies and organizations working together may indeed take a little bit longer to get started but in the long run, it will pay off royally. We must think forward to the future rather than reacting to a single focused crisis. There will always be another. We must act appropriately. And, last, we must require creativity and innovative approaches. We have to put an end to narrow thinking and cautious approaches and avoid repeating failures and also marginally effective approaches. We must update ourselves and our approaches and remember that controversy is not always bad it is just that we have to know how to deal with it appropriately. Controversial issues are those that get noticed, and planned and delivered appropriately, they will get results. Thank you.

CHAIRMAN WATKINS: Let me first say that this panel is the first panel that gets an A for staying within the reasonable time lines we have asked you to stay within. It is very helpful to us because we do want to ask a lot of questions, and it helps us more to get your concise thoughts and let us go from there. So I would like to start on my left with our public health expert on the Commission, Ms. Kristine Gebbie.

MS. GEBBIE: You always make me nervous. It sounds like you are going to give me another assignment.

CHAIRMAN WATKINS: I am. I am thinking of one.

MS. GEBBIE: I thank all of you. You did a very nice job. I think my first question is to Dr. Osborn. From your perspective in a school of public health and general awareness of what is being done in health education research and development, you know that in the minds of a fair number of people, health education is just so much fluff. They look at things like anti-cigarette campaigns and the continuing use of tobacco or think of it as eat sprouts and jog a lot and you will be healthy. Can you comment a little more on the substance that is available in that discipline to help us in an educational campaign?

DR. OSBORN: I can comment that there is substantial substance to that discipline. As you know, I am a virologist and a pediatrician and not a professional in the area of health education, but at the School of Public Health at the University of Michigan, we have a collection of some of the most distinguished faculty in that discipline and I am learning from them. I think that it is clear, and Paula said some of this very nicely in her presentation, that if one looks at AIDS education or health education in general as a series of glitzy advertisements or a catchy slogan and so on, one gets the kinds of results that we have become used to thinking of as the inevitable disappointing outcome of that.

I think that there is lots to be learned about how to motivate the public to invest their own energies and attention and their own health, and one of the things that we can turn to advantage in this dreadful epidemic is some learning opportunities in both directions, not only can we try with special vigor because of the urgency to try new and test new and different modes of health education, but we can learn from what is happening because we are, in fact, seeing a revolutionary level of success in health educational messages when those messages have been even partially delivered to communities at substantial risk.

I think, and perhaps you have already had this information brought forward, that it is a stunning fact that in those communities that are identified as communities, in the gay

communities in New York and San Francisco where volunteer groups have worked very, very hard to conduct health education programs, the reduction in virus transmission has been dramatically more than any prior organized health educational effort has ever yielded so I think we already know from this epidemic that we have got lots to learn, that it can be learned quickly, and that this is a very important time, both to try health education initiatives and to study the efficacy of them because this is going to be a problem for a while. We have got a chance to back off and regroup and if we do it very well and learn what it is that is more effective than prior efforts, we can make a big dent on things like smoking and some of other factors that contribute to massive heart disease and smoking mortalities in this country and elsewhere.

So I think your question suggests that there is lots of progress to be made in health education. I agree with that, but I think there are superb professionals involved. Their constant chorus is: as we move forward in AIDS, we must be evaluating what we do so that we do not just assume that a give slogan is good because we think it is good or that something is going to make a difference because it happens to be impressive on the spur of the moment; but that we genuinely study better ways to have effective intervention in the interest of the health of the public.

MS. GEBBIE: As follow up to that, can you see the schools of public health as one of the places that evaluation could be taking place, and are you getting some support to do that now?

DR. OSBORN: We see that as an exceptionally important contribution that we could be making to the epidemic. At the moment, I do not see any suddenly easier mode of support. We are fortunate, as I say, at the University of Michigan, to have a group of faculty in that area who are very highly regarded and we are beginning to try to divert the attention of other distinguished researchers in our university to this important area of intervention in the epidemic with some success. But I think there are ways that that could be stimulated more effectively. You see, while we have a Department of Health Behavior and Health Education and a discrete faculty, there are a number of schools of public health where that is not true, and where it is a little harder to focus the stimulus. I think there are things that could be done rather modestly in terms of the overall cost of this epidemic that could propel people into this area of investigation and endeavor.

MS. GEBBIE: My second question is really one to Ms. Van Ness and Ms. Mulder. I hear sometimes what almost sound like contradictory messages of the need for an overall campaign and the need for a professionally-mounted one, using professionally prepared health educators, and then also the need for community

unique campaigns and the use of innovation, creative techniques. In fact, the evidence that we have heard before that Dr. Osborn just mentioned that self-propelled communities working on their own have done better than anybody else so far on this epidemic. How do you fit together that local innovation and effort from people who have no professional credentials from health education schools which seems to work with this idea of a highly organized, highly professionalized, federally mounted campaign. Does that fit together, and what are the pieces of it that work?

MS. MULDER: I believe, Kris, that essentially we need to work together on all levels, and I believe this is going to be most important. Yes, a federal campaign is important, but I believe that it is also important for the Federal Government to encourage a lot of local efforts and a lot of local people working together. I believe that in our local communities as well as at the state and federal level, we have to launch an approach that is multi-dimensional. The approach must involve not only the professional education so that the people are receiving the right information consistently, and good quality education, but also that we are launching multi-dimensional approaches.

We have a program in the schools, we have a program in the communities, and in the different communities within communities. We have programs that reach a lot of different individuals and organizations so I believe is that a professionally prepared person needs to direct these efforts. But I do not believe that you can only have professionally prepared people because, as you have indicated, there are a lot of efforts going on that are indeed working. The important point that I believe we have to remember is that the approaches that we take must be multi-dimensional. They cannot be single focused programs. You cannot just do a program in schools and expect the results that you want to have, and you cannot just do a program focused at target groups and expect to get the results that we want, need and require.

MS. VAN NESS: I would just add that I think our view of a national program is that if we do our job, we can actually come underneath the local programs and help support their work. And in fact, we can learn from local programs and perhaps try some strategies and techniques nationwide that have been discovered at the local level. We can support their efforts, do things that perhaps cannot be done on a local level, but that need to be done, and that by working together, in this sense, duplication of effort should not be seen as a bad thing. It will take a number of different messengers to deliver messages in order to get the American public educated about AIDS. We need to employ a number of different techniques and strategies, and, in fact, if it takes 14.2 times to hear a message, then we need to be sure to say it at least 15 times. So in that way, I think

working together and achieving the coordination that was referred to earlier is tough, since people do have a sense of turf and territory. We do have to work together and try to respect that but also to move forward because this is a crisis and it demands the best of us.

CHAIRMAN WATKINS: Dr. Lilly?

DR. LILLY: Thank you. Several of you have mentioned with Mrs. Gebbie that there has been measurable progress in one respect. In other respects as well, but I wanted to pick up on the one that, in fact, the evidence for transmission of the virus within the gay community has suggested that that transmission is going on at a very much lower level. That we can all be proud of, everybody in this country, and in particular the gay community that did this by their own efforts to a very considerable extent. On the other hand, I was extremely encouraged that Ms. Van Ness mentioned the continuing need educate the gay community because in a sense, certainly this hearing to date, hardly anyone has mentioned the gay community. It is almost as if the feeling is that the gay community has taken care of itself. It is fine now. We can totally ignore it. We can go on to other things.

So I would like a little bit of comment on that perhaps, and then one more very specific point. If the gay community has accomplished that, it seems to me that part of that has been the nature of their approach to the educational message. Yet the gay community has taken a huge amount of criticism over the idea that if you are going to try to get people to change their sexual behavior, then one way to do that, and maybe even the best way is to eroticize those things which are remaining as things that are not risky. The gay community has tried that approach, and I would like to hear your ideas about the effectiveness of that because it has, from some quarters, brought a great deal of attack so these are my initial concerns today.

DR. OSBORN: I would be glad to initiate some comments. I think the first topic you brought up, Frank, was the one that I feel very strongly about, and that is the danger of inferring that because the New York and San Francisco structured and open gay communities have achieved a level of reduction in transmission in the virus that we are all excited about, that that takes care of the gay community in a different sense. We are using the word "community" in two ways there, in that one thought, and that is a serious hazard. I think we have learned, if we did not know, that there is a very substantial fraction of our population as a country who are gay or bisexual and that they all deserve to be warned appropriately.

Many members of that "community" (in that sense) are covert in their sexual orientation and absolutely not in the position to even go up and pick up a brochure that is aimed at The Gay Community with a capital g, capital c; that is a different sense of the term community and one that we are going to make a big mistake about if we assume that because of these localized successes in the optimal circumstances for communication, that we have now protected a group at very serious risk of the virus. We have not, and I think that the covertly homosexual individual in a small midwestern town is probably at least at as great a risk now as at the beginning of the epidemic because there is, in fact, reason in that person's way of living to avoid receiving messages that are directed to an open target.

It is part of that that I mean when I talk about being sure that we use national signals and community based signals to attract the attention of people who cannot openly confess what it is their risk behavior is. This goes for experimentalists in drug usage as well. I am proud to say that the state of Michigan has launched a marvelous educational campaign, and I am even happier to say that the networks and the TV stations in the state of Michigan-as soon as they saw the dossier of material that was available said "Great, we will volunteer time." So we now, in the state of Michigan, have running a series of marvelously attention getting ads that are aimed at getting the attention of people who think they are not at risk.

There is one, for instance of a laid back looking, rather well dressed, late adolescent young man saying "AIDS is for druggies. I just shot up once to see what it was like". Then a voice comes on saying that is probably the most dangerous time because sharing injection apparatus is what the risk is. "What you do not know can hurt you. Call this number". And then there are trained individuals at the other end of that hotline number who can psych out why the person is calling and what kind of help is needed.

I think we need to do more of that, perhaps for the covertly gay community than almost anybody else because the extent to which their identification with the community is buried is probably greater than for other people, by virtue of the societal homophobia they have had to deal with. I think in the context of the second part of your comment or question, I find it difficult to reconcile my concept of what this country stands for in terms of individual worth with the decision to arbitrarily limit a message of warning about this virus to some framework of pre-determined behavior that some group is going to determine. I think we cannot make silence and the punishment that comes with that the price for unaccepted sexual behavior on the part of some self-defined authorities.

I think we must use the language of the intended listener if we want our listeners to understand us, and I think that language must be adapted to the groups at risk and the people at risk who do not see themselves as members of any group. I find it difficult to reconcile any restriction of that kind; as I said, words are our ammunition in this war, and to restrict any of them or to restrict ideas that will best deploy those words and make them acceptable to the groups we are trying to warn, I find that very incompatible with my sense of what this country is about in terms of individual worth .

As I think you know, I had occasion to say so in Senate Committee testimony and so on, the kinds of things that the Helms Amendment represented back in the late fall, I think are antithetical to what it is we need to achieve. We need to be educating and we must stand by our commitment as a country to the fact that ideas are free and we must be able to communicate them in order to build what it is we are trying to stand for as a society.

MS. MULDER: I would just like to add a statement to that. I believe that if we continually emphasize a particular target group, the gay community or the IV drug users or whatever, what we are encouraging is the attitude in general public, that "it cannot happen to me". I am not going to get it. I am not at risk. "I do not practice any risk behaviors". They may not know what the risk behaviors are and I believe that by focusing very narrowly upon a particular target group all the time, that we encourage a false sense of security for the general public. They then believe that they are not at risk because they are not practicing one or two of the risk behaviors that they hear so much about.

DR. LILLY: That is an interesting and important point I think you just made.

CHAIRMAN WATKINS: Do you have any follow up questions?

DR. LILLY: No, not at the moment.

CHAIRMAN WATKINS: Ms. Pullen?

MS. PULLEN: No questions.

CHAIRMAN WATKINS: Dr. Lee?

DR. LEE: When we first started to organize our work here, one of the problems was whether to put prevention under education or whether to put education under prevention and after many, many discussions, the most fruitful of which was with Roy Widdus and his staff, we decided to put prevention at the top because that was the name of the game, and put public health and

education secondarily under that. Now, you all have said many interesting things. Dr. Osborn, when you used the term the urgent duty to warn, you used it in a completely different way than we normally speak of it. I was sort of interested in that. This panel, I agree, is education as a preventive measure, but our Commission has to obviously look at all sides of it. Now, yesterday, we heard some extremely persuasive testimony from Dr. Vernon and his panel that you are all familiar with. Contact tracing, I know you, Dr. Osborn, have come down on it a little, has a certain je ne sais qua with AIDS because if you prevent one case of AIDS, you are preventing a death, not a venereal disease, and if you prevent one baby from catching AIDS, you are doing, if you do not mind my saying so, God's work. We understand education is important. How does the Dean of Public Health feel about public health measures in this disease? We have to look at this, and we want to hear your side on that particular issue.

DR. OSBORN: I apologize for its lateness, but with the rules of the New England Journal, the paper that I wrote addressing much of what you have just asked only appeared two weeks ago so as I walked in the door, I have provided a copy of the script that I think you can see in somewhat better developed form than I can ad lib here how I feel about that. But perhaps to take the example that you used of what your perception of what it is I have to say about contact tracing may be a way to work into the topic.

No, I have no problem with contact tracing. I have a problem with mandatory contact tracing because I think it is a contradiction in terms, and I think it leads to behavior that is antithetical to the goal of prevention of further spread. It leads to, I think, encouragement of anonymous sexual behavior because then nobody can be mandatory about what you have to say. If you do not know who you had sex with, you cannot identify them later so my concerns about so-called classical public health approaches are not about the approaches, but about their mandatory application to a situation in which voluntary, private, consensual behavior is necessary for further transmission of the virus.

I think it is time we learned that we cannot legislate against sexually transmitted diseases. We must use other strategies to get into the context where sexual transmission of disease occurs. I think that we are lined up with the angels, if you like, in terms of trying very hard through voluntary means, to encourage people to reduce their number of sexual partners, preferably to monogamy or chastity in the appropriate circumstances and age groups. There is nothing different about these goals, and there is nothing intrinsically different about some of the mechanisms to achieve them.

It is that concept of "mandatory" that I find to be antithetical to what we are trying to do. We are trying to get to the most private part of people's behaviors and say "Change those, it is too dangerous now!" Even one new case should be preventable. We should not have any more transmission tomorrow if we were doing our job well. As I said in my opening comments, this is really, in a sense, a kindness on the part of fate or God, however you like to put it. We have a terrible epidemic; we have a disastrous new virus; but for the first time in history, it can be avoided. People who want to can avoid this virus by personal decision making, and it is sufficiently inefficient as a transmitting agent that even partial successes in health education lead to better than we deserve in terms of interrupting the transmission. I think that is the basic message coming from the gay community studies; that a partial response to health education messages gets you a bigger payoff that you even dared hope for because it is a poor virus. It does not transmit easily.

But mandatory approaches have already reinforced a bias I have against that way of trying to deal with private behavior. We can document, in some states early in the epidemic that when it looked as if the alternative test sites were going to be places where confidentiality was not necessarily firm or where anonymity could not be secured, that all of a sudden there was an enormous dilution of seropositives by people who were frightened for poor reasons; and people stayed away in droves who wanted and needed to know their own serologic status. There has been enough documentation of that so that it is not idle speculation on my part that the sense of mandatoriness, the sense of a social hammer coming down once you have somehow identified yourself as at risk, is one of our worst public health problems.

We need to have people feeling capable of being forthcoming, to learn where they stand and to amend their private behavior accordingly. We cannot amend it for them, and I think that is a social lesson it is way past time we learned: that in this free society (even in a not so free society) some of the behaviors that people do not like have been going on since the beginning of recorded history and before; and what we need to do is to use education as the way of improving on some of these public health techniques.

<u>Mandatory</u> contact tracing (by virtue of that "mandatory") can drive people to anonymous sex and away from counselling. Contact tracing, <u>voluntary</u> contract tracing is a standard public health technique. It is my understanding that, to the extent personnel allow, it has been practiced by every public health group in the country throughout this epidemic as well as with sexually transmitted diseases clinics; but the scarcity of personnel does not even allow voluntary contact tracing. In that sense the issue is a very ugly straw man.

Everybody wants to have mandatory contact tracing. We cannot even do our voluntary job because it is understaffed.

DR. LEE: I am very happy to get that clarification for the record. It is the mandatory aspect that you focus on, and in that this Commission is in agreement with you. Could I hear from the other panelists on that?

MS. VAN NESS: I think because this is a hearing on education, I would like to remind us all that the success of counselling and testing programs or even contact tracing programs goes back to a one on one interaction between someone who is knowledgeable about the AIDS virus and how it is transmitted and someone who needs to adjust their behavior. In fact, the success of those programs comes out of getting those two people together, giving them a chance to talk, to exchange information so that the person who needs to change his/her behavior will have a better understanding and receive some support. So that in actuality with these programs is really marrying education with those public health measures. They have to go hand in hand and that the good public health programs that are in place recognize that and support it. But again, in light of the lack of adequate staffing, the time pressures and so on, we have not yet even seen the program be as successful as it might be at its present level, let alone adding new layers of services on top of that.

And taking it a step beyond what you have said, I would like to say that at the same time we provide counselling, and testing services, we must also have comprehensive programs going on within the community so that the people are touched in all different ways with different messages. Therefore you are not only doing one thing or targeting one area, but it is a comprehensive approach.

DR. LEE: Okay, Admiral Watkins, I just want to make sure for the record that we appreciate these distinctions because they are important for our report.

DR. OSBORN: If I could follow through, I picked up on the contact tracing, but to follow, just reinforce the point that you have brought out for me, in the paper in the New England Journal, I bring out a few areas that I think we have neglected. I think, for instance, that we need to make voluntary testing and counselling very much more available than it is right now. I do not think that patient-physician relationships are very sturdy in a lot of places, and I do not think that somebody who goes to his physician once every two years and plays golf with him every Wednesday is likely to say,"by the way, I have had a little sexual encounter that was bisexual and I want to get tested". That sort of thing is very unlikely in our present way of delivering medical care.

DR. LEE: Happens to me all the time.

DR. OSBORN: Well, I am impressed with your rapport in that case; but I think that there are ways of making voluntary testing very much more accessible. I think some of them are dealt with in terms of some of the legislation that is or is going to be before the Congress soon. They are dependent on volunteerism, confidentiality and anonymity as needed in order to work, and they need to be thoughtful. For instance, it is not uncommon to have the only "alternative testing site",(so-called) in a large city and located in the middle of an area where everybody is afraid to walk; and then there is a several week waiting period before somebody can get on to the list to be tested and a several hour waiting period before they get their blood drawn and then they are told that within a little while, two to three weeks, they will hear an answer. That is not lined up directly with the goals that we share for this epidemic.

So, instead of focusing on mandatory this-and-that which will drain our counselling resources and will cost vastly more than any prevention component that comes out of it, I think there are ways of taking those kinds of resources, psyching out the situation and figuring out ways to bring people who are genuinely worried into the testing context where they can be counselled and either reassured and counselled to avoid further risk behavior or, if they happen to have become infected, ways of protecting their loved ones. I think these are very important parts of our response to this epidemic and the word mandatory is getting in our way.

DR. LEE: Thank you.

CHAIRMAN WATKINS: Dr. Primm?

DR. PRIMM: I think that one area where we are tremendously lacking is our understanding of sexual behaviors that are risky whether they be homosexual or heterosexual behaviors. We do not talk about them, and I was very happy when you talked about sexual behaviors and our lack of understanding and knowledge about them. I wonder what is being done by you, Ms. Mulder and Ms. Van Ness to certainly bring some of these sexual practices to the fore that could be recognized as being risky behaviors. I know for me, a man of 59 years of age who has travelled widely, been a widower for the last 13 or 14 years, that I thought I was in kindergarten at the advent of AIDS when I began to learn about some of the sexual behaviors that are practices, some that I never would have imagined.

The other thing is CDC often uses a reduction in, say, syphilis among the homosexual men in selected sites to give credibility to the effectiveness of education. When I look at this, and I think that is wonderful to see this reduction,

particularly in syphilis in some of our major cities, I think of my communities where there is no reduction in syphilis, where there is a precipitous rise in syphilis and chlamydia and all the other sexually transmitted disease. I wonder what the CDC is doing when you talk about a rise in syphilis among heterosexual population and particularly blacks and Hispanics in certain areas. What are you doing to focus on that? You need to reach that population despite the fact that you see an increase in condom use, etc., etc.

MS. VAN NESS: I would like to go to the first part of your question first. There is a great deal that we do not know about sexual practices today in our society as I said before, and of course, there are different interpretations about what constitutes risky behavior. To remember that some of the projections about the impact of this virus on our society were based on Kinsey results back from 1948 should lead us all to have some questions about how prevalent homosexual and bisexual behavior are in our society. In addition to that, what do we really know about sexual practices within the heterosexual population? There have been some small scale studies recently that have indicated that anal intercourse is practiced far more regularly than people would have imagined. One study even said as many as 40 percent of heterosexual couples engage in anal intercourse. That took some people by surprise and it certainly has an impact on our educational messages as we reach out.

There have been some committees that have been looking at the area of behavioral research and what is needed. The National Academy of Sciences has a panel now that is working with the Centers for Disease Control in looking at future directions. One of the proposals that has come forward and has been dealt with is to analyze what kind of information we need to collect about sexual practice today in order to better address the wider population with educational messages. I think that research is something that we can look forward to.

In response to the second part of your question, unfortunately I am the person to answer that because my area of focus is AIDS only. There are a number of people within the public health system and at the CDC, in fact, whose role is one of bringing STD's and AIDS together through an integrated approach in terms of sexually transmitted disease clinics and education programs. I really cannot answer your question, and I would hope that you can get your question answered from Dr. Cates or someone whose job it is to really address syphilis. We know that if we get the message across about AIDS prevention and we help people change their behavior, it will have an impact on other sexually transmitted diseases. The evidence is there that we are not doing our job and that we have a great deal more to do.

MS. MULDER: I think your comment about the rise in sexually transmitted diseases is a concern that I have as well, not only the rise in sexually transmitted diseases, but also the lack of success that we have had in the area of teenage pregnancy. I think that this indicates that our educational approaches have not been ultimately successful. They have not really worked, and I think it means that we need to look at new ways to do this-- new ways of education, new creative and innovative ideas and we have to be willing to try new things. We cannot continue to repeat the same kind of a message to the general public and to people at high risk, that is, of using condoms or abstaining from sex because it has not worked before and it will not work with AIDS either.

DR. PRIMM: One more question, Ms. Van Ness, and that is I think you sometimes leave prevention and education efforts up to the states, and I think somehow that that is not exactly what you should do.

For example, in Florida, in Belle Glade, let us take that specifically. Here is an area that has been visited by everybody, including CDC many, many times, has sponsored programs there and I have visited there some, oh, about a month and a half ago, and went into the neighborhood, looked around and spent about two hours there. There was not one poster or one educational tool that I saw in that whole community despite the fact that this Commission had been there, you had been there, the National Institute of Drug Abuse was there, Health and Human Services, of course, sponsors programs there, and not one poster there. You and I were just in London and we saw all over London and certainly in Paris and in Geneva, at bus stops and on buses and illustrations in Norway and Finland where people have very candid illustrations about what not to do and what to do to avoid this problem.

Here we have the highest incidence and prevalence in the community, and we do not have one thing there. CDC sponsors a program. My concern is why does not CDC, why does not whoever is responsible for these things, get posters, get materials so that these communities that are the most severely affected by the problem, the Harlems of this nation, the south sides of Chicago, Detroit for example, many areas there can have these materials. I am concerned about that.

MS. VAN NESS: I share your concern. The tradition at the Centers for Disease Control has been to work very closely with state health departments. They, in turn, work with local health department, they in turn work with their local communities. That is a rich tradition and there are a lot of programs and good things that have come out of that. I think what the AIDS crisis has brought us to is an understanding that there is much more that can be done to strengthen that system as

well. Our efforts to work with national organizations that have affiliates across the country, to work with religious institutions and educational institutions acknowledges that we cannot just rely on state health departments and their relationships to do the whole job. That has been something that we have been building. Probably in some ways of looking at it we have come to this understanding rather late in this crisis. It is very difficult to work with so many constituencies because of the coordination that is required and the sense that we do not want some people to undo the good work that others are doing. There is a balancing act there.

In answering one of your questions about why do we not see more posters or more evidence of these programs, the easy answer is there has not been enough money. This is true, but there are more complicated answers. There is a great deal that we need to do in terms of sharing information or materials that are developed in some local areas that others could then reproduce and use on their own. We have not had the kind of networking and sharing of information resources that we would like to see in the future. We have not, at the federal level, developed the number of materials that we would like to develop and are developing now. Our program is not yet even a year old so we are moving as fast as we can but there is a lot yet to be done. Once we develop materials, we have got to get them out there. I said before we are sending out a million brochures a week from the National Clearinghouse, the largest other civilian clearinghouse in the country is doing that many in a year, and we are doing it in a week.

There are a lot of materials going out but it is still not enough. I think in continuing to work with state health departments, local health departments, national organizations, religious institution, on and on and on, that we will begin to see more evidence of this. Keep in mind the scale, you know, when you have such a large country, the level of effort that it takes to make things so visible.

If we were in private business and we were going to launch a new soap product, we would spend about $5 million testing in test markets how to get the message out about this soap. Then we would spend about $50 million rolling it out across the country in order to get two percent of the market to buy our soap. What we are talking about is reaching 100 percent of the American public with basic AIDS information, a lesser percentage with very specific prevention information, and we are not spending anything near that amount of money. So we have to look at it from that perspective.

CHAIRMAN WATKINS: Dr. Walsh?

DR. WALSH: I do not envy you your problem in education at all because I am certainly discouraged about where we are at

this stage of the disease. Unless we become too optimistic about thinking that a smattering of posters or a plethora of posters all over the buses will make much difference, I think we have to remember that when the British, the United Kingdom, started their big campaign a couple of years ago, there was an awareness factor of 92 percent of the people in the United Kingdom were aware of AIDS. When they finished, it was 95 percent, and recent reports that I have read indicate that they have been very discouraged by the lack of the effectiveness because they are having many of the same problems we are, the spread in the minorities and that their education is not reaching people, and I think you raised some questions to us. I think one of them was whether we felt the Federal Government should put out behavioral guidelines and I would hope to heavens never, not in this country. I do not think the Federal Government should rule on behavior of any kind.

I certainly agree on the mandatory testing. I think most of the Commission does feel that way, and I do not think Dr. Vernon in any way was urging mandatory testing. He has been urging voluntary testing, but more broadly, applied.

I have some confusion on what we can do, and this is really addressed to you, Dr. Osborn, on behavioral modification because, as you say, you cannot change behavior by legal means. Certainly that does not mean that you want to legalize the use of intravenous heroin, and yet this is a classic example of where regardless of the penalty, we are not changing behavior.

Last night, for example, I had to go up to New York and I spoke to a rather large group of physicians in a city that is overwhelmed with AIDS.

I do not think it would be a surprise to you, Jim, or the rest of the panel to find that from the questions I received from physicians not only how little they knew about AIDS but how little they knew about what their rights were, obligations or fears were. When you talk about mandatory or voluntary testing, they were even afraid to ask their patients about behavioral patterns in some instances. They were afraid to confront them and question because they had heard so much in the media and so much in the press that they may be violating somebody's civil rights to even ask them a question that they may end up with a lawsuit. And, again, I think the task of education is where does it begin and where does it end and yet we have been wrestling with AIDS for maybe seven, eight years now. What steps Ms. Van Ness, have you taken to evaluate your educational procedures? We have had several witnesses who have literally begged for some evaluation of education procedures that they are doing even in their own states, and it would seem to me the CDC would have a very serious interest and they may have, but I just do not know about it, but in on-the-table, intense evaluation of why what we

are doing is not working, before we start off with another group of ideas that also may not work.

We can guess as to why they are not reaching Hispanics and why we are not reaching the blacks and so on, but maybe they know more than we think. We do not really know. We tend not to replicate the network of the gay community in San Francisco from the standpoint of education, and I do not think we should delude ourselves and the nation that behavioral change can be modified that much through the whole country in all groups. We still do not know what has happened to the adolescent homosexual as to whether or not he has been affected by the network education system. At least I do not know, I have not heard anything about it but you have raised, I think, many, many questions, all good ones, and all which demand answers, and I would welcome any further comments you have on answers because we could ask you questions for the next two hours.

DR. OSBORN: I am happy to take on some of the sense of your question. I think one of the things that frustrates me the most in this epidemic is the occasional comment from somebody that, well to choose a very pure example of it,"education has not worked in the drug community so how can you advocate education when it has not worked in the drug community?" My answer to that is "how can you know whether it has worked or not when you have given no options to the people who are caught in that kind of behavior?" I was thrilled at Admiral Watkins statement as carried in the New York Times last Thursday, and, in fact, I had the privilege of spending two days in New York Thursday and Friday in what could be described as a "show and tell" of the New York epidemic for a lot of the people involved in it, and then for a few of us from out of state to try to say what we thought might be done to cope, and so on, so I had a very heavy two days.

It started with Bob Newman talking about the situation with drug addicts and you may enjoy what he had to say because Admiral Watkins' comments had been carried in that morning's newspaper. He got up and he said,"I have a script here and a talk to give you; but I do not know what to say now. What I have been saying for 15 years just got said by somebody in authority on the front page of the New York Times. I feel like a puppy dog who had been chasing cars all his life and suddenly caught one?"(which I think is a great phrase) Then he went on to point that having your endorsement of one of the very most obvious things to do is only a first step, and that we have to be every bit as aware of the forces that kept this obvious thing from happening before as we are of the need for it to happen. I think that that is a terribly important thing in the context of drugs, and I think it can be generalized to some of the other issues that we have at hand.

Saying that education has not worked for seven years is in the same context to me as saying that drug addicts did not die of anything when we have tried.

DR. WALSH: I did not mean to give that impression. I do not say we have not worked. We have been struggling with it. It has worked to some extent of awareness. I was wondering whether that has worked in behavioral change.

DR. OSBORN: Well, I had the privilege of working with Dr. Lilly who drafted some of the education section of the National Academy of Sciences report; he and I also had the interesting pleasure of working with some very exciting people in drafting that overall report, and it was interesting to watch some of what I will call "high tech" friends come around gradually to the awareness. Now, I am a "high tech" type, too. I am a virologist and I used to do molecular biological stuff in the laboratory; but they came around to the awareness that this is one time when the technology we are interested in is that of education. Once you have said that, then interesting set of options comes up. If there is anything our country is good at, it is selling things, and we have not tried to <u>sell</u> our education for prevention. I have a one-liner that I use when I am giving talks. I say,"I do not want the public health people to seem too greedy about how much effort should go into this education thing, so I will settle, for starters, for equal time with the U.S. military recruiting advertisements."

That is a pretty good example. I will bet everybody in this room could tell you that "Be all that you can be" is the slogan of the U.S. Army; we have got to have that level of awareness of AIDS. It is a new fact of life for our children, and it is every bit as important to know about AIDS, that it is not spread by toilet seats and that it is spread by unprotected anal receptive intercourse and it is probably spread by just a lot of other forms of sexual intercourse, and that sharing of intravenous drug injection apparatus is a very dangerous thing to do. That should be as innate to our children as the meaning of red, amber and green on a traffic signal; and you do not get that by a glitzy poster or an occasional TV ad, and you certainly do not get it by not having that glitzy poster and <u>not</u> having any TV time.

I must say I was distressed about a sequence of events back in September when I was here for another meeting and some colleagues in the U.S. Public Health Service called and asked if I could stop down at the Humphrey Building and make a radio spot for our national educational campaign for AIDS awareness and prevention month. I had known from Paula Van Ness that there were great hopes for having at least some kind of a saturation effect during the month of October with a set of accurate messages delivered often enough to overwhelm the inaccurate

messages which are coming from all corners to wit: "Do not pay any attention, they do not know what they are saying, it certainly is spread this way, mosquitoes are worth worrying about" and so forth.

You hear that stuff almost more than you hear the rather diluted and watered down versions of purified messages about AIDS so that in fact, if you were a person from Mars coming in to listen right now, you would probably believe in mosquitoes more than you would believe in the validated modes of spread and the inability to spread the virus some other way. Anyway I was asked to make a radio spot because "we could not afford prime TV time" in order to get this message across. They asked if I would mind if they made a video tape at the same time so that in case some stations wanted to volunteer, it would be available; so we did that, and to my knowledge, nobody volunteered. But the experience in Michigan is very interesting in that regard because everybody is assuming that when we say we want a national education campaign, we want to turn the air blue.

We do not want to do that. What I want to do with a national education campaign is mostly to reassure the vast majority of the public that: yes, we have got a huge problem here. It is never going to go away. We are going to need to know about it like traffic lights; and we are going to need to be very compassionate because we have got a quarter of a million young Americans who are going to die! There are 50,0000 families who are hiding their grief right now, and that is terrible.

I get into enough situations where I hear individual cases to script a TV show forever. I could go into a different business because there are awful things happening, and people do not even dare cry in public. I work with people for days or weeks on something having to do with AIDS and finally they will trust me enough to say,"By the way, I have a nephew who is ill now". "By the way, I have a niece who had a sexual partner who was bisexual and she now has Pneumocystis". Or somebody will call me long distance. People are hiding grief at a level that I do not ever know of in American history, because of public misplaced fear and because of an ignorant homophobia that we must overcome. We cannot afford to carry institutionalized prejudices against a substantial faction of our population and still respond to a national tragedy.

We have just simply got to grow up enough as a society to get past that. We have got enough stuff to do that will pull us together. The only thing new about this epidemic is the virus! All the problems that we are talking about are old as the hills so much so that people have given up trying and your statement about the drug treatment last week is an exciting example of what can happen if we use the stimulus of this epidemic properly. We can overcome some entrenched, stalled out,

tiresome problems that society has decided not to pay any attention to, by doing a thoughtful job on this one, but when we talk about AIDS education and whether or not it has worked in the past, I would contend we have not started trying, not with what this society knows about to do.

MS. VAN NESS: I could not add a word to that, but I would like to address the other part of your statement which has to do with what are we doing in evaluation. We must acknowledge that we are in the midst of a crisis and it would be really nice if we could try something today and know tomorrow if it worked or not. There are a number of longitudinal studies that are going on, including some demonstration projects that are now in their third year where some very important information is coming out on the value of counselling and testing programs, for instance.

We'd like to know if the knowledge of an antibody test result to someone who is negative have an impact on their behavior in the same way that we would think it would for someone who is positive? The results of these studies are coming together. They are being looked at, they are continuing on, and the information does need to be shared. There are also evaluation studies in place on whether or not a video gets information across. We do a lot of focus group research on finding out whether or not messages are understood by people. We test anything that we are putting out in writing to see if it is understandable. So there is a lot going on. It has just never been pulled all together in one package. I cannot hand you a book and say, this is AIDS evaluation or an evaluation of AIDS education. We are doing more to pull it together and one of the smartest things that has been done recently in my opinion, at the CDC is to actually have a behavioral scientist in the Office of the Deputy Director for AIDS who is coordinating the behavioral research and really trying to help us identify gaps, identify factors related to behavior and to develop a long term plan.

MS. MULDER: A couple of your points. Behavior change has been the expected evaluation for health education and so it has appeared, because it is such a long term commitment that perhaps we have not been effective. I think we as health education professionals have to make sure that we base our evaluation on other things on a step by step approach where behavior changes that can be proved in five years, eight years, ten years, yes, they are important-- but there are important things that we must evaluate before that fact. We all know that behavior change is dependent upon so many things, and just sitting down with someone and talking to them about changing their behavior may or may not work and probably will not. They go back out into the community, into an environment where it is going to be a lot more meaningful for them to continue those detrimental behaviors. So I think it is again important to emphasis the comprehensive approach.

Picking up on your point about where does education begin and where does it end, I believe we have got to start right at the beginning and never let it end.

DR. WALSH: Again, I thank you very much. As I say, I do not envy you. We all are in this area and I was just trying to be sufficiently provocative to get any germ of any ideas we could from the panel.

DR. OSBORN: Equal time with the U.S. military.

CHAIRMAN WATKINS: Let me pose the first question to all of you. It goes something like this--so far we have exposed what I consider to be significant flaws in the national system in dealing with just one aspect of this disease, just IV drug abuse. We have exposed another significant ill on the structure of our health care delivery. Were we not to have had AIDS at all, we would have been in very serious trouble in this nation. Witness the Health and Human Services report of two years ago on projected health of black and other minorities as it was called, witness the report from the President's Commission on Health, Fitness and Sports, on what the projected health problems of this nation were going to be in the next century. Witness the demographic change in the country which is giving us the embryo of a permanent underclass. How we were going to deal with the health aspects of that, the limited participation in Head Start, all of business and academia coming together and saying, my God, let us get on early adolescent development, let us get on prenatal programs, let's reach these children in preschool. Now we are starting Even Start, a program for poor children and their parents.

Are we not making a mistake in the fundamental health education, health promotion of our nation, whether it is in the work place or in the school, and I would just like to know, if you would just nod, do you agree, perhaps the HIV epidemic has exposed it almost more than any other thing in recent times, it has brought it to a head that we have to do something. If you agree with that, then you have got to agree that as we move into dealing with the AIDS-specific education effort, we should in parallel move aggressively to reinstate something much more fundamental in the education process in the nation and focus more heavily on trying to build a baseline of understanding of our own human biology.

It seems to me that unless we do that we do not have the repository to deal with what you said was surely going to be the next event, and we cannot even deal with the last event. We have got fundamental health problems. We have nutritional problems, we have teen pregnancy problems, we have the sexually transmitted disease explosion that we had testimony on yesterday. We are very concerned about the problems. We have got all the

other issues that have to be faced to build a lifestyle that is healthy, and some kind of respect for our own human biology and perhaps that of our neighbors. It is a baseline from which we can begin to build something that makes some sense to deal with this at every level of maturation that we have to deal with, including the adult society. Would you agree generally with those comments?

DR. OSBORN: More than generally. I would applaud them loudly. I think that you just summarized ever so nicely some of the thinking that went into my decision, for instance, in 1984, to leave a medical school faculty and become Dean of a School of Public Health The bad side of it is to say that we need to do it. The good side is to say that now is an opportunity to bring together the themes from public health and themes from individual medicine. Those two fields, I am afraid, spent a lot of energy fighting each other for a long time, but now I think the idea's time has come, and was coming even without AIDS. That is what I meant before when I said that the only thing new is the virus, that this will give us a stimulus to readdress some issues that seem tired or seemed insoluble or were put aside for a variety of reasons that are historical but not interesting.

We now have an opportunity to try and address the issue of how individual and public health can merge and be optimized. I think there is a serious problem in medical education with a failure to go beyond the individual and beyond the disease states, and I had the pleasure of saying, to the Council of Deans of the American Association of Medical Colleges in the fall, that it is now time for new physicians graduating at least to be conversant with some of the things that contribute to our teenage pregnancy epidemic; to be conversant with some of the things that contribute to that absolutely appalling gap in the health expectations of some of our minority populations as opposed to the majority populations; that that needs to be a focus of concern of physicians, despite the fact that their primary focus will be on individual health.

By the same token, I think public health needs to learn to work in a hand-in-hand kind of approach and avoid the separatism and degree of argument that sometimes led to greater chasms. Certainly the health care delivery system is the place where that has to happen the quickest and the best because, as you have heard when you visited what I have called the epicenters of this epidemic and as I have had occasion to hear, we are going to find out very quickly that if our jerry-built health care system gets broken down, we are not going to be able to reconstruct it. We have got to move in with some emergency measures now and think fast and intensively about how to put our money where our mouth is with respect to the opportunity of our citizens to enjoy their individual worth and dignity; the health care system is the place where they enjoy it the least right now.

CHAIRMAN WATKINS: But you know, there are so many demonstration projects nationally. You talk about community-based organization, religious organizations, what they have really done without any guidance from up here. They had to face the music in areas to bring a healthy environment to a difficult neighborhood. The Beethoven Project in Chicago, for example, Rich's Academy in Atlanta, people who have really worked very hard to solve their own local problems. They are not getting any kind of top level, integrated leadership support at every level all the way down. It has got to be recognized as a national issue, and all of those things have to be given more incentives and moved where they have proven successful. Many, as you know, have proven very successful in a variety of ways. Building that healthy environment seems to be a mission of this Commission, that we could spark that enthusiasm in the nation to go a step beyond because it subsumes AIDS as well. We heard some presentations yesterday about how you might package up a health continuum curriculum concept that would be acceptable to American society and would not smack of something superficial and something that is focusing on condoms in the third grade home room and that sort of thing, but rather a much more fundamental of our own understanding of our biology.

I bring it up because it has been a theme that, as I sit on the Carnegie Council of Adolescent Development, has a heavy focus now. These are not health professionals. These are people very worried about cognitive problems, about light birth weight. What is happening on disadvantaged children in the earliest stages of education and how at that time they are getting turned off. Experts can predict drug abuse by a factor of three in one child over another child at a very early point. They have data to prove that so it seems to me that this is one thing that a Presidential Commission could put a lot of emphasis on at the same time we are endorsing the AIDS-specific educational practices that are coming out of CDC and moving into the local communities.

But, you generally agree with that thrust. Obviously, you do. Okay. Now, another spin-off from that, because I think it is important that we find our level, where is the federal level in the kind of education delivery system that we might have on AIDS specific issues. Yesterday we heard that effective educational strategy will have to be allowed to vary from group to group and city to city and not be imposed from above.

What they need from above is all of the baseline of information, educational information, technically sound things that are coming from competent medical and other scientific bases on which to build their variety of strategies that may well differ so markedly across the nation. If they are thoughtfully done, all of them are the right answer. They do not need to be the same everywhere, and if we try to dictate up here, one, it

will not work, and two, it is going to continue to add confusion, throw a lot of dust in the air, when there are so many good things that the local community-based organizations in collaboration with business, schools and the workplace and so forth, can pull together.

So what I have in mind, then, is that information going to be provided in a way that allows that process then to work at the local level and where you might say that 15 different results based on local ethnic interests, local objectives, local mores, that sort of thing, are quite acceptable, and that we may give each one an "A" if they do it sensibly for their community. In other words, is it the information that they need to build that kind of an educational regimen in almost any community in the nation, or is it more directive in nature and is it more for increased information or you might say, how to change behavior in a certain direction. Could you give me an answer to that, Ms. Van Ness?

MS. VAN NESS: I think that we have to look at the various tactics that we are using; since they all do fit together. For example, the mailing that we are talking about, one piece to go to every household in America is a very difficult piece to write because of the great variations we have in peoples' reading level, their baseline knowledge before reading such a piece of material and, their need for information varying from those people who are not at risk at all to those who engage in very risky behaviors. I think we should look at the mailing as just one piece in the overall strategy and continue to work with state and local health departments, community based organizations, national organizations, making sure that when that mailing goes out, there is a support system there to handle the kinds of concerns and issues and needs that arise.

If we convince people by reading this piece that testing is something that they should do or they should look into, we have to make sure that the testing sites have an ability to serve them. If we prompt people to call the hotline, we need to make sure that the phone is not busy. I think there are broader issues about the overall level of support for these programs. As time goes on and more guidelines are developed and more materials are developed, we have to be sure that it is not from the top coming down but really that things are bubbling up. Our role is to help those local organizations do the job that they are there to do.

CHAIRMAN WATKINS: To what extent do you allow collaboration with people like Ms. Mulder and Dr. Osborn or others like them in the nation to take a look at your work at this point to say yes, that is very useful, that will be beneficial, and that is something we could lean on, then, and move into other areas of educational need?

MS. VAN NESS: We do a lot of that. We have brought together many groups of people in terms of leadership forums and so on. But going back to the mailing, just as an example, because that is one that we are working on now, we have convened a number of different focus groups across the nation to look at it. Members of the general public including people who are blue collar workers, married people, teenagers and so on have been consulted. About 200 professionals who are health educators or who are working in AIDS or in the public health field have been contacted to run the material by them to see what their reactions are, to get their advice and counsel on this project. I think we are tapping into the resources. There are very rich resources there. We could do a lot more, but we are always on a fast time line that we have to respect and there are limits to how far we can go.

CHAIRMAN WATKINS: There is a question in many people's mind about the effectiveness of mailers. I guess that is my biggest concern, and of how much change they really make in behavior or in some cases, even knowledge. I am wondering what is going out with the mailer in the way of other kinds of advice that might come in from the community based counselling services, public health and others? How are they coupled into the process to see that the effectiveness of your mailer is going to be maximized.

MS. VAN NESS: We would like the mailing to be one piece of a very large effort surrounded by a number of different activities and television shows and whatever we can do to support that effort. Congress has made the decision that a mailer is something that should be done. To have realistic expectations of that mailing is something that I think we all need to keep in mind. There is a need for some basic information so if we provide that information, are we doing an important job.

We have every hope that we will be in a position to do some pre- and post-assessment of levels of knowledge and even some self-reports in intended behavior change, but we do not expect that when someone gets this in the mail, they are going to read it and say,"oh, I am never going to do that again". There may be a few people that do that. There may be 50 people in the nation who learn that anal intercourse is something that is dangerous and they will no longer engage in that. That would be hard to measure. We look at the mailing as just one more weapon in our arsenal that we have got to fight this virus.

CHAIRMAN WATKINS: So you are talking about the strategy that goes just beyond the mailing, that there will be a public relations campaign, there will be integration with the public health officials or others that have to answer local

questions, local airing on a variety of networks and so forth, to be talking a lot about it.

MS. VAN NESS: That is right, and we are hard at work developing that strategy and talking to people about how we can work together to create a significant event.

CHAIRMAN WATKINS: Could you write me a letter and tell me a little bit about that implementing strategy? I am more interested in that than I am, I think, the mailer at this point itself. How you plan implementation because I think that is part of the national education process that each time we do one of these things they should not be done by just the technical professionals. It seems to me that there is a way to engage the entire American population in something like that if we do it properly. Ms. Gebbie, do you have a question?

MS. GEBBIE: I think it would be helpful if Ms. Mulder could comment from her perspective on sort of the reciprocal half of that. You heard from Ms. Van Ness what CDC has tried to do. I think there have been some strengths and weaknesses in that, and Ms. Mulder might be able to comment.

CHAIRMAN WATKINS: Surely.

MS. MULDER: As Ms. Van Ness has said, there are problems with a national mailing, and I think a lot of your comments have brought out some of the weaknesses of that particular approach. As far as their approach in involving state health officials and community groups and organizations and people who are going to be on the recipient end of this, I think that is where the professional education again comes to the fore. If we are going to do this mailing, we are not going to make an impact in many, many places, but we are going to raise questions and the professionals need to know how to answer those questions so I think there is a lot of groundwork that needs to be done first.

I also would like to say that I appreciate your comments, and I think the Commission has an opportunity here to require results from these kinds of efforts, from all of us in education. If you are going to provide us with the money and the resources to do this, you have the ability to say "I want to see what good this is doing", and I think we need to do that. We need to make sure that the good things that are going on in individual communities throughout the country get disseminated to other communities so that they can try some of those approaches that maybe they never thought about.

CHAIRMAN WATKINS: We had a follow up question you wanted to ask the panel.

MS. GEBBIE: The issue of public service announcements, Ms. Van Ness mentioned with I think rightful pride, the amount of coverage that the AIDS campaign has gotten from PSA's but in at least many communities there are serious questions of the effectiveness of that because of the hours during which PSA's are shown but also because of the contrary messages of sexuality that come through other paid advertising and through the content of the shows during which the PSA's are broadcast. Would you comment just a little bit on that?

MS. VAN NESS: When we are engaged in a public service campaign, we are essentially at the mercy of the networks and the local stations to work us into their schedules at times that fit. Essentially, when they have not been able to sell the time, PSA's air, and that is why we see the early Sunday morning and late night hours. If we could wave the magic wand, we would be better able to control when PSA's go on the air and how often they go on the air. We would be able to target our messages, like you target the sale of a new soap. We do not have that ability. So what we do is to try to work with public service directors to make sure that they will play the messages that we are delivering to them and to try to help them understand how they might help us in targeting these messages. There are deficiencies in this approach, and I think that has been shown in campaigns that have been studied over the years. There is a good amount of literature on the subject, and the same problem has come up for other diseases or other issues. As long as that is our approach, then we live with that and we try to make the best of it.

DR. OSBORN: But I do not think you should underestimate the power of a sense of national will in helping the decision making about when public service announcements appear. I think that our experience in Michigan has been very exciting that way because it turns out that we have not paid a penny for TV time or radio time in the Michigan education campaign because the Michigan Department of Public Health said "Here, we have got a package of materials that is a diverse package, it all needs to be presented;" and they started being ready to pay for it and the major TV stations in the Detroit area said, "Oh, well, we will carry that for free. Not to worry". At which point, the out of state stations said, "We will too". At which point the radio stations dove in, and my last information -- I am on the Public Health Advisory Council for the state -- and the last we were presented at our Council meeting, there had been no money necessary for TV or radio time in that campaign, only a couple of full page newspaper ads.

I think that the sense of unease and divisiveness on "is this tasteful?" and "is this national policy?", the failure to have it validated at the top as something that is important

for us as a nation to get hold of and learn about has contributed to a great sense of unease on the part of the networks.

I had the opportunity to testify just in advance of the three networks' vice presidents at a hearing that Congressman Waxman's subcommittee held, back last spring. Even then, when the conversation was much newer, what they were basically saying was if somebody would say this was national priority, we might say something different from what we are saying now. They are a very reactive industry. They have to be. Right now, the eddy currents and the muddled message or lack of message that has been coming about national will has led to the fact that PSA's go just before the sermonette at the end of the wee hours as Mervin Silverman likes to say.

I think that we might find that it was nowhere near as expensive to contemplate a blanketing of this message if, in fact, it were a coherent national will. I think the Commission has a tremendous opportunity in that sense, and it may not be a very expensive one. I mean, one of the nicest things we have been saying this morning is that the most effective weapon we have got is also in many senses the least expensive.

CHAIRMAN WATKINS: If we are able to do our task, as directed by the President, to give him a national strategy, and if we build it in a consensus building fashion as we tried to do with hundreds of witnesses, bringing the best in the nation before us and let the American public hear all the debate then we will have done our job and the American people will surely pitch in. I oversaw the shift to an all-volunteer military from the draft. It was the best thing we ever did. The volunteer spirit is very high. We are getting the finest people, a cross section demographically that we did not have under the draft and so these are good things for the nation. I think we are going to see the people who volunteer who are getting burned out and afraid that perhaps we are not going to put a sustained effort into this, I think you are going to see them all come back to life. I have never seen better reporting than on this disease. We have had a couple of exceptions to that, but basically people are concerned about it, they are reporting the right things, they are trying to stay with scientifically valid data but once in a while it slips away from them, but basically it has been pretty good. The major networks, the Public Broadcasting System, National Public Radio, have all been carrying these things for free, and they are ready to do more. Project Plus are looking for opportunities to help in this thing.

I know the entertainment community is beginning to look at their own subliminal suggestions that are really feeding the fire of AIDS and are trying to eliminate those. That is unusual. I think the opportunities are now, and I applaud this panel for the cohesiveness of your presentation this morning. We are going

to have to move on. We would like very much to keep the dialogue open with each of you. There will be more questions, perhaps, from us, coming officially from the Commission. We would like as rapid a turn around as you can give us so we can factor it into our thinking and you have an open door to the Commission at any time from this point on. Thank you very much, and we will shift to the next panel now.

DR. LEE: Chairman Watkins is locked in deep discussions out in the hallway, and I thought we might as well keep going. Dr. Shalwitz, could you start with your presentation?

DR. SHALWITZ: One million youth drop out of school every year. The youth unemployment rate is 14 percent which is 2.7 time the rate for adults; 400,000 youngsters are confined to detention facilities each year; 500,000 to 1.25 million youth run away from homes every year; there are 300,000 hard core street youth who survive by any means possible, including prostitution and dealing drugs, and in a 1986 study, one percent of high school seniors reported using heroin and 13 percent used cocaine in the previous year. The number engaging in intravenous drug use is not known.

The average age of first intercourse for youth in the United States is approximately 16 years although it may be as low as 12 in some communities. Only half the sexually active adolescents use a form of contraceptive at first intercourse. A third of the adolescent females use oral contraceptives. Only 10 to 15 percent use condoms.

One-third to one-fourth of adolescents have never used any form of contraception. One million adolescent females become pregnant each year and that is one in every ten females. Eight-five percent of these pregnancies are unattended. Thirty percent who complete their pregnancies are black, and 14 percent of the adolescent female population is black; 2.5 million teenagers are diagnosed with sexually transmitted diseases each year. Chlamydia is the most common STD. Gonorrhea, chlamydia and PID rates are the highest in young adolescent females, particularly those who are black and Hispanic.

According to the CDC, as of February 15, there were 226 reported cases of AIDS in youth between 13 and 19 years or age, that is .42 percent of the total 53,814 cases. Blacks and Hispanics who make up 12 percent and six per cent of the United States population, respectively comprised 25 percent and 14 percent of all reported AIDS cases, and 34 percent and 17 percent of the adolescent AIDS cases. Considering the current practices of sexual behavior, the prevalence of sexually transmitted diseases, and drug use, this suggests the future rate of HIV

transmission may exceed its present rate in adolescents, especially among minority youth.

When considering the incubation period and the great number of AIDS cases in their 20's which are approximately 20 percent of the total, adolescents must be considered at high risk for exposure. So, who are those who are hard to reach? I assume this Commission means that these are youth who are not reached by conventional methods of health education, through parents, schools, religious institutions and youth groups. I believe successful interventions in this population are entirely possible. However, education plays only a small role in the entire prevention picture.

In order to successfully prevent the transmission of HIV, interventions must be supported by policies and community-wide understanding. The following elements must be addressed in order to insure the success of any strategy: public policy which adequately addresses the goals of AIDS prevention; plans for addressing community support in education; identification of high risk groups and their documented needs in service gaps; untargeted interventions which are effective, relevant and financially feasible for the focus population.

In all aspects of public policy, youth, health policy and service delivery experts should be participating in every level of policy making, including probably the Commission. In terms of community support in education, there continues to be substantial misinformation regarding street youth of AIDS. The notion that street youth are the Huck Finns of the 1980's continues to prevail. In order to understand the AIDS risk of street youth, education must be coupled with information regarding the broader context of the antecedents and consequences of youth homelessness and delinquency. Community leaders, media experts and health officials, with input from youth service providers and youth must collectively develop and implement a multi-dimensional AIDS prevention campaign targeting high-risk youth.

Components of the campaign should include media exposure, community forums, provider education training and outreach workers. Community-wide education should be targeted to residents, merchants, community and religious leaders and legislators who live and work in or represent areas where homeless youth and other youth congregate. All youth service administrators and providers including those who work for probation, social service departments, health and mental health departments, policy and recreation departments should be educated as well as all those who work in community-based agencies.

Educational messages should include general issues regarding those issues of homeless youth, including culture,

behavior, beliefs and practices, information about risk exposure and transmission of HIV via sexual practices and drug abuse and the promotion of the acceptance and use of condoms and clean needles as a method of disease prevention. There needs to be increased depiction of minorities, heterosexuals, teenage parents and their babies and youth at risk and infected with HIV in all campaigns. Sources for additional information and advice such as hotlines and newsletter must be disseminated.

Identification of high risk groups. High risk street youth are not a homogeneous population. There is not one set of cultural norms or of common language. The problems, therefore, cannot be addressed adequately by a nationwide effort. Additionally, resources available to youth vary across the country. The target group and their needs must be carefully identified in order to properly plan useful intervention. For example, many AIDS risk production interventions stress the avoidance of drug use or encourage access to drug treatment services yet these services simply do not exist. Methadone maintenance programs do not accept youngsters who are under the age of 18 and the drugs of choice of intravenous drug-using adolescence are cocaine and speed, it is not heroin.

Intervention should not be planned to avoid controversy or additional identification of needs. However, it is incumbent upon policy makers and intervention designers to anticipate and plan for such possible outcomes. It should be expected that AIDS reduction strategies in high risk youth will increase the demand for additional resources such as long term and safe housing, stipend-attached job training programs, residential and outpatient drug and psychiatric treatment facilities, multi-service programs providing safe recreational activities and educational opportunities and crisis intervention services and respite care.

AIDS prevention, education activities for high risk youth should ideally have the following components. One, information conveyed must be accurate, simple, explicit, direct and non-ambiguous. Two, risk reduction activities and materials must be compatible with the social norms and values of the youth, and must be linguistically and culturally appropriate and sensitive. Educational aids should be audiovisual or verbal rather than written. Three, education must incorporate skill development such as decision making, assertiveness training, communications skills and self empowerment, and should be incorporated into a comprehensive family life education program which addresses all high risk behaviors such as violence, substance abuse, unprotected intercourse, STD's.

Four, the acceptance, use and free distribution of a wide variety of condoms should be promoted widely. Five, individuals who cannot or will not refrain from intravenous drug

use must be taught to avoid sharing needles, how to obtain and use clean needles, and/or how to clean used needles with bleach or alcohol. Six, youth must be incorporated into the design and implementation of prevention activities. Peer counsellors and outreach workers should be adequately trained and utilized wherever possible. Seven, staff workers should be well trained and receive updated information regularly regarding HIV infections and risk reduction practices. Staff must be comfortable with the youngsters, with their language and with their life styles. As much as possible, indigenous individuals should be utilized in the programs.

Eight, programs must offer a flexible and creative assortment of alternative methods. Behaviors and options which achieve the primary goals of eliminating further spread of the virus. Intervention should be modified according to the site of activity, whether it is in a restaurant, in a street, in a multi-service center, in a detention center, in a psychiatric inpatient unit, etc. Nine, messages must be consistent and engagingly repetitive. They need to be heard over and over and over and over again, and humor needs to be used as much as possible.

Ten, all prevention and intervention activities must be integrated into a comprehensive, coordinated service delivery system providing care to youth in general including those at high risk. Staff should work in concert with the local youth service providers and in collaboration with other AIDS outreach workers and service providers in the community. And, eleven, programs should be regularly evaluated for their effectiveness and meeting their design goals and objectives and modified according to the current information and changing needs and/or compositions of youth at high risk.

Since I am running out of time, I would be glad to answer any questions regarding the specifics of our program and particularly our obstacles, which the list is longer than those things that are needed to make the program fit the perspective.

CHAIRMAN WATKINS: Thank you.

DR. LEE: Could I just ask you to be sure to submit your statement in writing because you had so many good statistics that we need.

CHAIRMAN WATKINS: Ms. Price?

MS. PRICE: Thank you, Mr. Chairman and Commissioners. My name is Virginia Price and I am the Clinical Director of The Bridge, a street outreach and support service agency in Boston, Massachusetts. I am here today on behalf of the Child Welfare League of America.

The Bridge is a multi-service agency responding to runaway, throwaway, homeless and high risk youth in Boston. Our services include street outreach counsellors, free medical and dental services, teen pregnancy and parenting services, drug abuse treatment and two residential programs. We see approximately 2,200 young people each year, and we estimate that another 2,000 adolescents receive services from our workers on the streets. Our street workers spend 30 of their 40 hours at night, directly on the streets in the areas where these youth congregate.

The Bridge clients come from multi-problem families in which they were often the victims of physical, sexual and emotional abuse which has left many of them scarred for life. They have replaced the violence and chaos of their homes with the violence and the chaos that is endemic to street life. Drug and alcohol abuse is rampant among them. They have led and they continue to lead exceedingly sad and traumatic lives.

The story of Kathy is typical. Kathy is a 19-year-old white female with ARC. She is the middle child of three from a middle class family. Both of her parents are alcoholics and she is the victim of violence in her family throughout her childhood. She is an incest survivor and she has also been sexually abused as a child outside of her family. She also has a learning disability. At the age of 13 she became a chronic runaway. She had a total of six placements in foster homes, and at the age of 15 she became involved in IV drug use. She has been enveloped in prostitution since her first runaway episode when she was 13 and she is also the teen parent of two children, the second of whom was HIV infected.

Because of clients like Kathy, in 1983, our medical coordinator foresaw that AIDS would pose a major threat to our clients and began to train herself and staff members about the disease. Since 1984, we have been offering AIDS education to our clients. Initially, our clients were very resistant to it because they perceived it as being a gay disease. What we have learned over the four years that we have been offering AIDS education is that AIDS cannot be addressed as a single educational issue but must be addressed in the context of the continuum of services that our clients both want and need. We need to work with these clients, not just to educate them about AIDS but also to help them to muster the courage to begin to examine the overall high risk nature of their lives, and to initiate necessary behavior changes.

In the counselling and the medical components we do formal AIDS education. We have adapted general educational materials from the Massachusetts Department of Public Health to better serve the comprehension level of our clients. In other words, we have translated mutually monogamous relationships to

sex with only one person. It is essentially that we be able to talk to these children in language that they understand and in non-clinical terms. It is important to understand that our clients were not sexually abstinent prior to coming to us, and they are unlikely to be after education. Remember that these teenagers were probably sexually abused as young children. It is our goal not to moralize but rather to educate in realistic terms in order to save lives. Having spent many years working with these teenagers, I can attest to the need for latitude in being able to determine individually what works best for each youth.

In order to evaluate our efforts, in the summer of 1987 we conducted a survey of our clients to find out what their level of knowledge was about AIDS and what impact our educational efforts had had with them. For our survey, 152 young people completed our questionnaires. Based upon their responses, we found that 37 percent of our clients reported that they had histories either of prostitution or of IV drug use. What we found was that a higher percentage of those clients reported that they were at no risk for AIDS than did our overall clientele. We interpret this as seeing that beyond education, we need to do clinical work to begin to confront the denials in these youth's lives.

They did report that they had made changes in their behavior; 81 percent of the youth involved in prostitution reported that they had somehow modified their behavior as a result of AIDS education. Thirty-four percent reported that they were practicing safer sex; 25 percent had stopped and 34 percent reported that they were only going with known tricks which does not effectively reduce their risk for AIDS.

A similar profile emerges for clients involved with IV drug use. Eighty-four percent reported that they had changed their drug use somehow as a result of learning about AIDS; 46 percent had ceased IV drug use; 25 percent reported that they were cleaning needles, and 17 percent reported that they were not sharing needles. From this survey, we have learned that our clients are somewhat more likely to cease IV drug use than to exit prostitution as a result of our efforts. To date, Bridge clients who have developed ARC or AIDS have almost all had histories of both IV drug use and prostitution.

From this survey, we have learned that our clients fall into four categories after AIDS education. First are youth who cease their high risk behavior and need ongoing counselling and support to maintain the changes in their lifestyle. Second are youth who bargain about what behaviors they will change, and who need intensive education about the continued risk for HIV infection. Third are youth who deny that their behavior places them at risk for HIV infection, and who need a strong clinical relationship that can pierce their denial system. And, finally,

in the smallest group are youth who use high risk behaviors as a means to act out underlying issues of anger, depression and suicide, and who need intensive treatment to begin to address these issues. While this is by far the smallest group, we believe it is the neediest group.

The funding picture is bleak. Bridge estimates that in 1983, we spent approximately $500 for staff training and education. In 1988, we are spending between $10,000 and $15,000 on AIDS prevention. However, I would like to make it clear that this is unique and that we already have a street outreach and a medical outreach program in place. We estimate that start-up costs for another program to duplicate our efforts would run in the range of about $200,000 a year.

On behalf of The Bridge and Child Welfare League, I would like to specifically recommend some important actions that the Commission could take. First of all, we need to have a clear federal policy on AIDS. We have been getting conflicting messages from the Administration regarding AIDS, and it is essential for community leaders and service providers to receive a clear and unified message from the government. Of particular concern are issues related to education of prevention efforts aimed at children and youth.

Secondly, we need effective education efforts. At this time this is our only weapon against the spread of the AIDS virus. Educational materials need to be developed by professionals who have an expertise in working with the various populations. We desperately need to continue effective programs, and to expand and develop new programs to reach populations such as these youth. What we need is a federal policy like the bill recently introduced by Congressman AuCoin that respect our ability as professionals to facilitate attempts to save the lives of our clients.

Further, we need to recognize the contributing social problems that lead to there being children living on the streets. Factors such as child abuse, poverty, poor education, mental illness, drug abuse, teenage pregnancy and unemployment all act as contributors to street life. It is no coincidence that HIV infection is prevalent among populations that have historically been plagued with other social problems.

Finally, we need additional funding. While money alone will not stop the AIDS epidemic, increased funding from the federal level is desperately needed in order to support existing efforts. Prior to the onset of AIDS, child welfare services were severely underfunded and overburdened. The Commission interim report is certainly a step in the right direction in its recognition of this basic reality. Please impress upon the

President that it is our hope and indeed our responsibility to tell you what we need in order to effectively do our job.

In conclusion, all of these youth are in need of ongoing services from agencies such as Bridge to address both the threat of AIDS and the multiplicity of the other issues in their lives. To date, in addition to Kathy, seven Bridge clients have been diagnosed as having either ARC or AIDS. One has died. The only means to combat this epidemic is a sustained effort in education, intervention and clinical support. Without this, youth who have already had extremely traumatic lives will be left to face an extremely traumatic death. Thank you.

CHAIRMAN WATKINS: Thank you very much. Ms. Patterson-Bucy?

MS. BUCY: Mr. Chairman and members of the Commission, good morning. I am June Bucy of the National Network of Runaway and Youth Services and our agency appreciates the opportunity to testify before you today. You have heard some figures about runway and homeless youth. Those figures are estimates. We do not know how many runaway children there are. We do not know how many homeless youth there are, and one of the major reasons we do not know is that we have never tried to find out.

The guesses and estimates range between 1.3 million or two million homeless and runaway children in our country for some part of each year. There is no typical runaway or homeless youth. They are young, the modal age of children coming to programs is 14. The runaway population is composed of boys and girls, white children, black children, Hispanic and Asian children, urban and rural, rich and poor, from every state and every Congressional district in this nation. It is not a problem just in big cities, nor do children only go to big cities. Children who run away from home and who enter the programs which collect the data that we have, (and we do know a good deal about children who come to shelters), hardly ever leave their own home community. They are children who have been forced out of their homes and who would like to go back. If, after several runs, they have not been able to be reunited with their family or to find some satisfactory place to live in their own community, they may go to a larger city or somewhere else, but that is not the point of intervention for most young people.

We have provided in our written testimony some working distinctions between runaway and homeless, systems kids, street kids and missing children, and I will not go into those now. But I would like to point out that many of these children simply circulate through our system. Many of the children who permanently live on the streets have been taken from their homes most often after an abusive experience or sexual molestation in this home. They have been moved from foster care to foster care

to substantive care to something else and something else. Finally, the children decide this is getting them nowhere. They run away from the system. No one looks for them, but they are there on the streets.

Perhaps the most important thing to remember about these children is we do know where they are. Not all of them, and we do not know how many there are, but we do not have to look them up to find them, nor do we have to invent programs. There are good programs like the Bridge which Ginny told you about, and Youth Advocates, where Dr. Shalwitz often works. And we do know what to do with these young people. Our problem is we have no national will to do it.

Many of these children have been forced from their homes by families that are often very dysfunctional. A boy is asked to leave because the family resources are inadequate to care for him. Food is scarce and he eats too much. Another because a parent cannot accept a son who thinks perhaps he is gay or others because parents cannot handle an acting out or depressed adolescent. In the majority of cases, the young people are running away from something. They rarely run to anything, or have any conception at all of where they are going or what will happen when they get there. They are running from painful situations and they often encounter more serious problems and more violence on the streets.

Homeless and street youth face unique barriers which prevent their receiving effective AIDS education or prevention techniques. We should, however, realize that the programs that have worked out systems of dealing with these young people have had good success as Ginny has just told you, but we need the collective will to provide more programs and to meet those children where they need to be met. The barriers to providing effective AIDS education and prevention for runaway, homeless and street youth are formidable, not the least of which is in treating the symptom. The temptation may be to ignore the root problem. We must give food, shelter and education to children, but should not we also ask why are hundreds of thousands of young people living on our streets homeless without any supervision or care from adults? We must take this long term approach or we will simply be creating other children who will be victims of AIDS as well as never having a chance to be productive citizens in our society.

Effective strategies do exist. Some are already in place. Others are in the process of being developed. New strategies need to be funded and present once expanded. The National Network is the primary service agency which works with homeless and runaway youth programs, and we have recently inaugurated through a grant from the Center for Disease Control an AIDS education and prevention project called Safe Choices.

Features of this project will be incorporated into my discussion.

The first thing we need to do is reconnect those young people to their families and to their communities. Doing so will make it easier to link them with medical and educational services. I think there are two really, really bad things that happen to young people on the streets that most of us who are not familiar with the children do not think of. One is they are completely disconnected from medical care, and the other, they are almost completely disconnected from educational services. Bad things happen to kids on the street, but along with that are the good things that do not happen. There are access to services that children, and all of us, need. Our reconnection strategy must be comprehensive with the positive, supportive relationship of caring adults. Youth on the streets, particularly if they are to get off of the streets and if they are to change their behavior, need to feel they belong to someone and to something. Their low self-esteem and their self-discipline must be built up.

I remember the story of a street worker who was beginning work on the street and going out where the kids are and the first night she was there, it was almost overwhelming, the swirling people, the noise, the confusion, the suffering young people. She grasped the arm of the person who was helping her learn and said, how do you start? A very wise answer came and that was, "learn their names". In an anonymous world of uncaring strangers, to be called by your own name is again to be linked with a human family, and this is the first step of empowerment and the ability for young people to begin to control their behavior. Reaching out to troubled youth implies a commitment to serve the youth where they are, both physically and psychologically in language they understand, with methods adapted to their levels and types of learning.

Runaway and homeless youth are on the move. They are on the street, they live in shelters, they eat at fast food restaurants or out of dumpsters. They hang out in video arcades or other places on the street. To be successful, our prevention activities and information must reach them where they are, in language that is clear, direct and concise. We must provide current scientific information that is constantly repeated, then reinforced by staff at every level in ways that conform to the vocabulary, age and lifestyle of the youth. But correct medical information is not enough. Prevention and behavior control must be stressed, again and again.

Prevention education must be skill based. Providing information is not sufficient. Saying no may be the goal, and it is important, but it is not enough. A skill-based curriculum must teach young people how to practice saying no, how to

withstand the pressures from their peers, so that abstinence can become a reality rather than just an impossible ideal. Counselling in the use of condoms must be coupled with information on where to buy them or get them, how to use them, and their limitations. All drug use which clouds the thinking processes must be discouraged and must be seen as dangerous for young people.

AIDS prevention education, therefore, must reinforce the necessity of altering and modifying high risk behaviors. It cannot do so through penalties and censorious language but by persuasive arguments, devoid of judgment, or judgmental attitudes, which clearly point out the consequences of high risk behavior. In doing so, our education must endeavor to stress the fact that seems to get overlooked sometimes in our rush to preach about the deadliness of AIDS. That is the truth that sex is good, that it is a gift of God to young people, that human sexuality is a positive force. The AIDS epidemic could lead us to be sexually responsible, help us to choose life while we are preventing the spread of the disease and help young people be emotionally and psychologically more healthy.

For youth who do contract AIDS or ARC, our training must somehow help them confront their mortality, and to come to terms with living out in dignity and acceptance the time that they have left. Coming to terms with the issues of death and dying, however, applies not only to the youth, but to adults who work with them. Adults must be trained to identify their own values and feelings in these difficult areas. Adults in runaway shelters often feel deep anger, great discouragement, confusion. Why do we let this happen to our children in our open and caring society?

To help them admit and channel that anger into constructive ways can enhance the effectiveness of counsellors with youth and prevent their burn-out. It can reinforce the message that there are positive ways to deal with this potentially destructive feeling. Programs must also adopt corporate policies that will enable them to act with safety and confidence with their young people and with their employees.

Throughout, there has been an insistence on presenting AIDS education in the language of facts, but in communicating our message to youth, the language of facts is not enough. Our language must also be sensitive and compassionate. This sensitivity extends not only to the words we use, but to the music behind the words. If we truly wish to reach out to runaway and homeless youth, we must leave the safe confines of our language and our world, and risk entering the world of youth who need not severe judgments but our compassion. Compassion is not pity, it is an honest attempt to enter the world of pain and both empathize and sympathize with the plight of others. The language

of compassion is ultimately the language of hope, and if there is one message that will help runaway and homeless young people turn about and change their behavior, it is that message of hope. The challenge that we face in reaching the thousands of hard to reach and homeless youth with facts about AIDS is to educate the youth effectively for their own empowerment. It is to tell them lovingly yet unequivocably, you do have a choice, and your decision with our help lies in your hands. If we have the national will to make the needs of these homeless children a priority, their potential will be redeemed and their future and our own will be immeasurably enriched.

CHAIRMAN WATKINS: Thank you very much. Ms. Johnson?

MS. JOHNSON: Admiral Watkins and distinguished members of the Commission, I am pleased to have this opportunity to appear before you today on behalf of the Children's Defense Fund to discuss the complex problems faced by low income and minority youth across the country who face high risk of HIV infection. We share your concern for youth at risk and hope that the issues raised by this panel and others today will receive your continued interest and commitment to action on behalf of these children.

The Children's Defense Fund is a non-profit organization which exists to provide a strong and effective voice for the children of America, and we work to improve conditions today so that all of our children can be productive an effective members of our society tomorrow. National statistics tell us that there is much work that remains to be done on behalf of children and families. You have heard a lot about the children who are at risk today. I would like to talk a little bit about some of the children who are at risk tomorrow.

The first high school graduating class of the 21st Century will enter first grade in September of this year. These preschoolers are the future leaders, workers, taxpayers, soldiers and American hope of the 21st Century. Many of them are off to a healthy start, but millions of them are not. Today, one in four is poor, one in five is in risk of becoming a teen parent, one in six have no health insurance, and one in seven is at risk for dropping out of school.

Our society is aging, and the number of children and the percentage of youth in relation to other population age groups is declining. Now is the time to invest in our future. If current trends continue, a disproportionate number of our young will grow up poor, undereducated, and untrained at the very time that our society will need then most. Moreover, as a result of growing health risks, too many of our children will be lost to preventable death and disability. My written testimony addresses the excess health risk of HIV infection faced by low income and minority children, the health status indicators which point to

the depth and breadth of risks which are faced by black and Hispanic children, and the lack of access to health care services that exacerbate the risk for poor children whether at birth or throughout their childhood. I would like to use most of my time today to discuss the essential steps for preventive investment strategy for children. Whether it is new statistics for epidemiological studies, results on research of the virus itself and its transmission or anecdotal studies about the lives of those infected with HIV or sick with AIDS, new facts about the spread of HIV infection appear daily.

The growing body of evidence points to some very troubling trends. Among the most troubling of these trends is the growth in the number of young children with the HIV infection. We know that children from families living in poor, urban, minority communities are facing a greater risk of exposure to HIV than other children and that exposure includes increased risk of sexual assaults and victimization, of contact with contaminated needles or persons who have used them, and birth to an HIV infected mother or father. As with poor and minority children, poor and minority women of child bearing age are more likely to live in a community with a high incidence of HIV infection, and the statistics that are available to us indicate that the risk of HIV infection among minority youth also is high.

We know that the early cases of AIDS among adolescents were primarily reported among children with hemophilia, and that the screening of blood and blood supply products means that now the risk of transmission through sexual activity and HIV and IV drug abuse is a larger threat to the health of teens. The risk of HIV infection while existing for teens is a much lesser threat than the risk through sexual activity. We know that just in terms of heterosexual activity and sexually transmitted diseases, our statistics indicate some significant risks for HIV infection. An estimate 83 percent of males and 74 percent of females are sexually active by age 20. Among young women age 15 to 19, 45 percent of whites, and 59 percent of blacks are sexually active. Among Hispanic women age 15 to 19 of any race, 47 percent are reported to be sexually active and sexually active teens have the highest reported rates for sexually transmitted diseases of any age group.

In 1986, reported cases of gonorrhea totalled over 8,000 among 10 to 14 year olds and nearly 216,000 among 15 to 19 year olds. In that year, reported cases of syphilis included 155 cases among 10 to 14 year olds and over 3,000 cases among 15 to 19 year olds. It has been estimated that one out of every 17 currently has a sexually transmitted disease. We know that exposure to HIV infection compounds the health risks already faced by low income and minority women and children. The financial and racial barriers to access to health care have left

low income and minority women and children in reduced health status.

The volumes of the report of the Secretary's Task Force on Black and Minority Health describe in detail many of the disproportionate health risks faced by members of the community. Two recent publications by CDF address the health risks faced by low income and minority children and pregnant women. Financial barriers to health care have grown in recent years, in part because more individuals and families lack access to health care coverage and the availability of public health services eroded in the first half of this decade as the number of poor and uninsured children increased.

There are four essential governmental responses that I wanted to address today. First, there are three key reasons we must invest in basic public health services that are essential to the prevention of HIV infection. One reason is that they provide a base for information training and screening activities. Second, public health programs already serve millions of poor and minority women and children and are identified with disease prevention. Third, public health programs serve as a source of information on the pace of the epidemic. Screening for HIV infection in health centers and sexually transmitted disease clinics and high risk communities can increase our understanding of this problem.

Second, we must use schools creatively in the fight against AIDS. Schools are an important public institution which can provide essential health and family life education to prevent the spread of HIV. While many of the youth at greatest risk have left school, the time for prevention of further dropout and high risk behavior is now. Youths who by age 18 have the weakest reading and math skills compared to those with above-average skills are nine times more likely to drop out of school, eight times more likely to have children while young and unmarried and face a host of other risks, and we know that regardless of race, youths from poor families are three to four times more likely to drop out of school than those from affluent households. Furthermore, one in five poor teens with lower than average basic skills is a mother, regardless of race or ethnicity.

Third, we must design health education programs to reach high risk adolescents in and out of school. For teens who are in school, communities across the nation must adopt programs which incorporate health and family life education into the basic curriculum. The objective for the nation's health state that by 1990 every junior and senior high school student in the United States should receive accurate, timely education about sexually transmitted diseases. What could be more timely than a curriculum which provides information about sexual activity, its

risks, the risk of HIV infection and other sexually transmitted diseases.

For teens who are out of school, new and existing community based systems must be used to provide education about the risk of HIV infection. For low income and minority youth, individuals and institutions with a connection to the community, may most effectively communicate such information. It struck me earlier, during the first panel, that a more simply way to put what I have written in my testimony is that it is not just the message but the messenger.

Fourth, we must invest in basic programs designed to keep children health and productive and to encourage delay of sexual activity. We already know a great deal about how to help children and their families. Children need care and attention not only from their families, but from the society as a whole. Preventive investment in our children is essential to the prevention of HIV infection. The successive programs to improve access to health care among poor families has been documented. The federal Chapter One and Head Start programs, both designed to enhance the skills of disadvantaged children have demonstrated success in building basic skills and improving the chances that children stay in school.

Child welfare programs designed to meet the needs of abused children have demonstrated success and yet the tattered patchwork of programs that we have does not nearly meet the needs of coverage for those children, and we know that an increasing number of families and children on their own across America do not have homes. In a recent report, the Committee for Economic Development stated in this way the national self interest in investing in children. This nation cannot continue to compete and prosper in a global arena. When more than one-fifth of our children live in poverty and one-third grow up in ignorance. If we, as a nation, cannot compete, it cannot lead. If we continue to squander the talents of millions of our children, American will become a nation limited of human potential. It will become tragic if we allow this to happen. America must become a land of opportunity for every child. The HIV epidemic brings an additional burden to this challenge I believe. If we allow more children to become infected with the HIV virus and suffer the pain, debilitation, and death that so often results, we will not only have failed these children, but cause irredeemable national harm as well.

CHAIRMAN WATKINS: You have given us a very sobering picture. You have also just made me destroy the draft of my speech to the Children's Defense Fund Convention next week so I will have to go back to the drawing board and try something else. I would like to commence the questioning on my right with Dr. Primm.

MR. PRIMM: First, I would like to compliment Ms. Johnson on highlighting and bringing to the fore the plight of minority youngsters in this country, and the kind of very fertile area in which they live and have to survive that make them more susceptible to HIV. I think along with what you have said goes something else that I think is a contributory factor and that is the stress around them that further makes their immune systems more vulnerable to infection with the virus. I need not say much more from my perspective because your report covered pretty much what I would like to say about it so I will pass Mr. Chairman.

CHAIRMAN WATKINS: Dr. Crenshaw?

DR. CRENSHAW: I, too, want to thank you for bringing this information and data to our attention. I want to tell you that I think what you are dealing with in our children even though it is the wholeness, it represents all our children and is at the heart of the ultimate threat of this AIDS infection because our adolescent kids are the ultimate high risk group. What really concerns me is that if I understood your statistics correctly that about 200 or thereabouts have been diagnosed with AIDS, and that there, I could not hear you very well, was it 2.5 million STD's, sexually transmitted diseases, among teenagers. The sexually transmitted diseases that are already present and the one in seven who has a sexually transmitted disease and then the one in five at risk for teenage pregnancy certainly demonstrates the potential for the spread of any sexually transmitted disease among our teens.

I hear public health departments and people say well, 200 is a small number, but I will never forget when there were less than 200 in the gay community only seven or eight years ago; and I would dread to see history repeat itself, and I think the gay effort will have lost impact if we do not make use of it and learn and apply their suffering and their tragedy to the rest of society. What I want to ask you, and this is something that I have struggled with and I have not come up with solutions, every panel or witness that has talked to us about adolescents or teens or sexually transmitted diseases is so relieved and grateful that someone is listening. They are having such a hard time getting the attention of the community at large. What can we do? We cannot allow this to continue. And where are the obstacles in waking up the world? They care about children. How can we reach better and get the resources that we need?

MS. BUCY: That has certainly been a frustrating experience for us. Programs alerted the National Network three and a half years ago that they were finding kids who were seropositive within their populations with whom they were working. We tried to get the word out. We went from federal agency to federal agency, we went to private foundations, we went to insurance companies. Almost universally the response was,

"oh, I never thought of that". I might say not only did these children reinfect each other, but kids who are living on the street and prostituting are being prostituted by people who come from the community of "nice" people, the community that thinks it is protected. When men come down and prostitute little boys or young girls who are diseased, they can take that infection back to their families.

DR. CRENSHAW: And not only that, I might add that these kids, while they are in foster homes and going through the transition of getting to the street and in between prostitution and drug use, are going to school periodically and are interacting with the community that thinks they are safe and separate.

MS. BUCY: One of the things that concerns all of us a great deal is that we know the populations of people who have been identified as most likely to be at risk of AIDS have often been scapegoated. They have almost been threatened and pushed aside in our community. We do not want that to happen to young people, even, and most particularly to those young people who have no protection, and no attorney to defend their civil rights. Although I feel that we have tried to draw attention to these problems youth have, we really do not want our high risk young people to be scapegoated. We prefer to think of high risk behaviors, in whatever we do. An article in Psychology Today spoke of high risk of AIDS in children who are living on the streets, particularly in New York. That is rare, but we feel also that it is important to protect those children from the kind of fright and the pushing aside of homeless children particularly minority children as this epidemic gains speed.

DR. CRENSHAW: So what can we do to help and where can we apply the pressure and the heat to get you the kind of resources that you need to help all of us protect our kids?

DR. SHALWITZ: For one thing, I do not want to dwell on the problems because we could be here all day, but services to youngsters are incredibly fractionated. There is not a comprehensive approach, and as you all know, when you feel sick or not even when you feel sick. Let us say you start off in the morning and your car breaks down and you get a headache and you get a stomach ache, you are late to work, you get in trouble, etc., it is like your whole body travels together in time and place, and you know how important your housing is and how important your medical care is and how important your whole body needs packaging.

Youth are so again fragmented and there is one approach in the Federal Government called Youth 2000 that is being spearheaded by Secretary Bennett and others in which there is an effort to look at how to develop comprehensive policies and

procedures in terms of approaching the issues of youngsters. There is a pittance allocated to it, but it does encourage people to comprehensively address the issues of adolescent substance abuse, adolescent pregnancy prevention, housing, and education, and these kind of efforts need to be supported from other places such as yourselves and also need to be encouraged to address the issues of adolescent health and sexually transmitted disease and pregnancy prevention. It also has to be coupled with all high risk behaviors and AIDS prevention which should be incorporated into all these strategies. Again, it is just a pittance of money. The whole federal effort maybe is $450,000 but that is a start.

Your recognition and acknowledgment that youth are at risk and need our attention is something that is of vital significance and just mention them as one youth, one at-risk group but they are a special group that requires all of our attention and concern. These people, the people who we work with and we serve have no political clout, have no money, have no machine in place to rise to the effort. In San Francisco, where so many wonderful, wonderful things are going on, there is barely any attention to homeless youths or high-risk youth. We get almost no AIDS money. None.

DR. CRENSHAW: They have you which is very fortunate, and I could talk to you all day, but it would not be polite, and I am sure that there are many others interested, but since it is lunch, perhaps after the panel is over, I could chat with you a little further. Okay?

CHAIRMAN WATKINS: Ms. Gebbie?

MS. GEBBIE: I am wanting to leave aside a little bit the whole prevention piece about which you have all been very articulate but I think that is something that deserves a great deal of attention, and focus on that body of kids that are out there now for whom primary prevention did not work, and they are not in school.

The education grants that come out from CDC for youth education all say kids in school and then kids not in school as a second group, and all of the groups that have received money for that are expected to reach both kinds of kids. That implies, and in fact, overtly states, that somehow you could do AIDS education with these kids not in school almost as a freestanding effort. The more I listen to you four, and put that in the context of other things I know, the more I am impressed that trying to do AIDS education with kids who are not currently in school as a freestanding activity is almost futile, that it would have no meaning were it not in the context of a more comprehensive package of health or education or support services. Yet, that almost sounds like we cannot do anything if we do not do

everything which is a very difficult approach to take to any problem. I would appreciate some discussion or clarification on that issue.

MS. PRICE: I do not believe that we have to do everything for every kid. Unless we have services the kids want and need, we cannot do the education. We cannot go out on the streets with the sole purpose of providing AIDS education to kids. We need to have food. We can sit down at a meal with them and talk with them about AIDS. We need to have food, clothing, showers, a place to stay, the possibility of employment. These are the things which are attractive to the kids. It is not that we have to address every one of these issues in order to do AIDS education, but if we do not have something to help these kids, they will simply walk away from us. Now, if we go out in the streets and say to them, I want to talk to you about AIDS, and that is all that I have to offer to them, they are not going to relate to me at all.

MS. GEBBIE: But to have at least one of those other things that they need, do you think it might be effective?

MS. PRICE: I think you have to hook it to a number of different things that they need. You cannot just say that they need food, they need shelter, they need medical care. Our strategy has been to have comprehensive set of services that are available to kids and then to integrate AIDS education into each component of our program. Some kids come in and all they use is the dental service but as part of the evaluation that is done with them, somebody would talk to them about AIDS. Or they may come in just to get a place to stay that night, but again we make the effort to talk to them about it. So it is having a range of services available but not necessarily expecting that all kids are going to utilize all of these services and change their lives.

MS. GEBBIE: Thank you. That was helpful. Did you have a comment about something?

DR. SHALWITZ: I just wanted to add that another thing kids in the street really benefit from is just contact, friendly contact, and the AIDS workers who are in the street with the kids, hang out, they spend their time hanging out, engaging casual conversation, just shooting the crap with the kids. Basically, they start exchanging this kind of information, start doing risk assessment, STD risk assessment and suddenly the condoms come out and the bleach comes out, and tables get set up and there is lots of distribution. Again it must be people who are trusted, who are considered to be friendly folks out on the street and who mind and respect the rules of their territory and do not come out there preaching. It just simply will not work,

but again it can be imparted with the right folks out there, and with the right training, with the right heart.

MS. BUCY: I think I would like to say that there is a piece of legislation called the Runaway and Homeless Youth Act and that legislation funds programs, 311 this year. The money goes directly to community based programs. It does not go through any kind of state planning or it is not in the control of anyone except the federal authorities who administer that program. These programs have been in place for the last 20 years, a growing number all along. They have had investigations by the General Accounting Office, and by the Inspector General's Office who have come back invariably with reports saying these agencies do what they were intended to do: they do get kids off the street, they do have more self-referred children than children who ever leave them without permission. They are open, caring programs. The kids know about them and communities approve of the programs. The efforts that we can make, particularly for the runaway and homeless youth, do not have to be freestanding in the sense that there is nothing out there now.

There are some really good things going on in all of the major cities and in many, many small communities, but the money that comes from the Federal Government is about a third of the money that these programs have, and every program that I know is absolutely strapped for money, for staff, for the ability to do what they know they can do, what children like, what children come for, what changes their lives. It is ridiculous that we know how to do things and we simply cannot get ourselves together. The total amount of money put into the programs by the Federal Government is $26 million, which is just pennies for each of the children who come to the program, much less for those who do not get there.

It seems to me that one of the things we need to do in this country is to decide to whom homeless children belong. Our child welfare, our child protective systems, do not do well with adolescents. They try to do permanency planning for their living situation. Permanency planning for a drug abusing 15, 16-year-old kid is just not going to happen. The child protective system has proved over and over again that they are overwhelmed when they try to deal with a high risk teenager. As a nation, however, we have no policy; we have no notion at all who is responsible for homeless children. Our schools can kick them out when they start skipping school or do not do well in school. The court system can put children in some sort of secure detention only if enough good police work has been done and if their crimes are detected. Families can just reject children, and there is no penalty whatsoever. Local government has no responsibility that is assigned by anybody for those children. I do not think we are going to get anywhere with homeless young people in this country until we recognize that they are there and

have somebody responsible for these very troubled children. We have not done that. Young people cannot go to adult shelters because the adult shelters do not have the license for taking care of minors. If they are not with their families, they simply cannot get into adult shelters, and there are no systems of homeless shelters for adolescents in this country so they are excluded for what few services there are for homeless people.

Many times if adolescents are with their parents and the parent, usually a mother, wants to go into a shelter, they do not let the older children in, particularly older boys, fearing that they will be destructive, or frighten others. I still think the fact that kids eat an awful lot discourages people from wanting them in their programs. They are disruptive and they are not allowed in. And these kids do not hang around. My church does feeding of street people here in Washington. You rarely see a young person waiting in line. They do not have to slouch on street corners and wait until somebody comes by to feed them. They get out there and hustle, but their hustling is destructive. I think we are very, very foolish if we do not use those agencies that we already have in place to reach out to more of those children with some kind of responsibility and capacity, some kind of opportunity for them to have a longer term place to live and the opportunity to get enough education to be productive citizens.

MS. GEBBIE: My second question is related to the issue of the barrier to making those things happen. Clearly, part of it is financing. I take it, from what you have said, that there is a network of centers and concerned people who are feeling very short of funds. We have experienced in other situations that a checkbook is not always the answer, and I think it would be helpful if you would, perhaps each of you concisely state, what you think is the biggest other barrier if the money barrier were not there. What is the biggest other barrier to dealing effectively with these hard to reach kids?

MS. JOHNSON: I will take the first stab while they are formulating their more program-specific responses. It seems to me that it gets back to the question that Ms. Bucy just raised, and that is, who is responsible for these children and whether or not we are taking responsibility for these children. I think that really is a very fundamental question and there is a barrier where we do not take responsibility and it gets back to something that Dr. Crenshaw raised for me. That is that until we identify that this is a national problem, that it affects all of our children or most of our children are sexually active and many of them are exposed to drugs or people who use drugs, and that they come from all races, that they come from all kinds of economic backgrounds, and then we have a subgroup of children who come from poor and minority communities who are at even greater risk, until we get to that point of having public understanding

of that as an issue, we continually face a barrier. Whether it is at the national level and the willingness to commit federal resources, or it is at the community level where you have a community that says, well, this is not really our problem, these are not really our children. We cannot take responsibility for this--at every level, that is a threshold question and as I said, there are some more detailed policy responses I am sure.

DR. SHALWITZ: There are number of other major barriers real specific to some things right on the street. Number one, the crack crisis on the streets is overwhelming. If things were bad on the streets a couple of years ago, they are so bad now it is out of control. Crack is easy to obtain, it is cheap, it is easy to deal it, the high is like that, the kids feel great, and it produces the fastest drug seeking behavior that we have ever seen in any other drug. It is a problem that is much bigger than all of us, and it obviously requires some incredible federal attention. As we see in San Francisco, there has been a lot of attention focused on law enforcement. So the kids get busted all the time, and then they get put in jail and there is no treatment, no support, no understanding of the problem, and there is this magical notion that if you arrest more people for drug-related crimes, you are solving the problem.

You are not solving the problem, and just because all of these statistics that have come out in the press a couple of weeks ago about high school students who are decreasing their cocaine use. It is because these kids are not in school, because they cannot function in schools and they are out of schools and they are in the streets and it is dangerous and it also has created a very violent place on the streets. There are lots of weapons, there is lots of fear. It is scary and it is much scarier for the street kids now, and I will tell you it is much scarier to do street outreach because people are afraid to hang out in the street. It is scary.

The other thing, minor other problem, besides crack, is that the kids tell us they are very annoyed about the media messages. We talk to them and we do education with them, and they come to learn that they are at high risk for disease, and they see posters, they see pictures, they see movies and the people do not look like them. A lot of the people are white, they are very beautifully dressed, they are very beautifully composed in these pictures and they say, who is it, why are not people like me in those pictures. They want to see themselves there and they want to get the validation that they indeed are at risk. So that is one thing.

The other thing that has been addressed in all of the panels since I have been observing here the last couple of days is that there is such a tremendous mixed message. You turn on the TV, people are having sex all the time, they do not ever

think about birth control, no less AIDS risk reduction, and until there is a message that this is appropriate behavior and it is commonly accepted behavior, it is just clearly not going to be heard and seen. Why don't those people start doing it? They need to put on their seat belts, they need to get out condoms, they need to talk to each other about sex and about everything. There is so much power in this entertainment and media world and hopefully it can be redirected so that messages become more clear.

Those, to me, are major obstacles. The last one, I am going to say one other major obstacle. The place where we have gotten a lot of our money to do education has been through family planning money. Family planning monies are drying up so that it is a twofold problem, the loss of those revenues and no source of new revenues for us unless there are definite monies that are identified for serving high risk youth.

MS. PRICE: I think an additional barrier which we see, it is very difficult to access services to these kids. It is extremely rare that you have a street kid who has not had a history of some form of treatment or contact with human services, and what happens generally, and I believe it produces street kids, is that they are stigmatized.

They are labelled as being somehow an acting-out adolescent and nobody is doing an assessment to really look at the family problems that contributed to their being in the position that they are in. There is nothing which mandates any kind of intervention with the family so that what happens is this kid who is labelled as being a problem child and in need of treatment and the larger picture is never addressed. These kids are very often scapegoated in their families and then when they become street kids I believe the scapegoating can also continue by different service providers, and I think that these kids are victims and that is something which people have to realize, that they have the history of victimization that goes back to their early childhood.

They are not on the streets because they are setting out to have a good time. They are there because that is, for them, a healthier environment than where they have been at home. I think that we have to have prevention efforts to work with kids before they get to that point, and the other thing I think which is difficult is that this victim blaming continues into the prostitution. When we are talking about adolescent prostitution, we are talking about adults who are paying teenagers for sex, and they are paying by and large, I believe, for sexual abuses that these kids have to predispose them to being involved in prostitution. There is very, very little intervention with those adults, and there are legal consequences for those adults, but instead the stigma is put on the child and it is the child

who people want to lock up, who people want to contain, and nobody wants to deal with the fact that there are adults who are very much contributing to this.

The only state that I am aware of is Oregon who makes no distinction between the purchaser of sexual services and the seller of sexual services. But what happens is that this contributes, this stigmatization contributes to a lowering of the self esteem of these kids, and these are not kids who feel good about themselves to begin with, and so it become harder for them to reenter into society when they have this stigma.

And, finally, along those lines, is for people to be really clear that not all runaways are involved in prostitution. I think that is something that the media has been, for various reasons, sensationalizing. It is extremely damaging to kids because what happens is the kid may run away from home, stay on the streets for two weeks, four weeks, a couple of months, and then try to return to their home community and in general, when they return, they now have the stigma of prostitute to contend with. They may never have been involved in any prostitution but it becomes difficult for them to reenter into their local high school when they are known as the runaway prostitute, and I think that there needs to be more accurate information through the media presented about these kids.

MS. BUCY: I could not agree with you more on the stigmatization. It seems that easily labeling all of these children or giving very, very high numbers for a prostitution rate, appeals to some people, including the media, but it is a very, very destructive practice. These kids often are not prostitutes. In fact, I talked with a program provider the other day that said many of the children are getting very good at stealing, that they have decided that prostitution and drug dealing is much too dangerous and so now they are picking up their skills and just plain ripping things off. I am not sure that is progress, but kids are forced to survive in whatever ways they can, and there are more means of survival than prostitution, and for many of the ways they survive, they should be congratulated and not forced into a victim sort of position.

We need to disabuse ourselves of the notion that raising children or caring for children well is cheap. It costs me a whole lot to feed my children, to take care of them, to get them educated, and for us to think that we can take children into the custody of the courts and become their parents as a recognition that their families have not functioned and that we can do it on the cheap is really pretty foolish.

I would say first we need to strengthen families. Many of these children run from families where there is a great deal of chaos. The best research and more that is coming in now

affirms that as many as 70 percent of these families have been places where the children have been severely abused or sexually molested. These are not kids whistling their way off to the circus because they were unhappy with something light and airy that went on at home. These are severely troubled children who come from severely troubled families, and many of those families can be helped. I have seen women with tears running down their face saying they know their boyfriend is molesting their daughter but he brings in the groceries. We should not force families into the position that mothers have to sell their children for groceries.

We can strengthen families, we can teach people how to be better parents, and how to discipline their children without violence and how to deal with alcoholism without taking out on children. I would like to pick up with what Ginny says, not only do we need to prosecute those people who prostitute children, but we need to prosecute those people who harm children within their own homes, and when the word gets out that it is no longer safe to beat up on children, that you can no longer molest children and nobody will know and nobody will care. When the word is out that this is a crime and you will be punished, I think it will have a great deterrent on that sort of thing that people now get away with.

Third, I have forgotten which of you mentioned this, but always in the Network and the Runaway programs, we have talked about involving the youth themselves. Many of our best answers for things that could be done and things that work come from the young people, and I would encourage anyone who is planning and implementing programs for young people to involve those young people in it. They can tell us whether they understand. They can tell us whether the programs meet their problems.

One of the problems that kids have which they will certainly tell us about is how easy it is to drop out of school. Teachers fuss, and they do not like the kind of work you hand in, and they do not like it that you are absent and pretty soon, you drop out and nobody much looks and nobody much cares. But have you every tried to drop back in school? That is really hard. There are barriers and once we get rid of those kids who are disruptive to our classrooms, we have a lot of ways to keep them out. This is particularly true for children who are homeless when they move from one school district to another, do not have a permanent residence or do not have a taxpaying parent in that district. We prevent their going to school, and that is not a very good thing to be doing.

We need more connections between our youth service programs and our medical schools or our public health training schools. Youth service agencies provide opportunities, wonderful

internships and placements for students where they will learn a great deal about how families function, or do not function, and a great deal about the kind of services that young people need Placing students on internships or rotations in those programs, greatly strengthens the program. At the same time, people are well trained in one of the underserved areas.

Universities can also be good sources of interns and staff people for programs. Although the university education is certainly an expensive process, youth service programs need very little money to be allocated to them, to supervise interns, student placements are an inexpensive way for them to get very good staff, and I would encourage you to validate that as a way of reinforcing these local programs.

CHAIRMAN WATKINS: Dr. Lilly?

DR. LILLY: I just have a relatively brief question. You absolutely overwhelmed me with facts, only a few of which I knew. One of the things that I did not catch until very recently when Ms. Bucy addressed the issue is the geographical range of organizations that cope with these kids. I know that in New York City, we do have some. We have some that are general, we have some specialized ones. We have one, for example, that is mostly interested in gay and lesbian youth, I think that is a very necessary one there. What about other large cities, what about medium sized cities, small towns and the youth there and the resources to take care of them in the other places?

MS. BUCY: There are programs across the country, in every state. The federal money is divided proportionately to the population of young people in the states, and there are needs all over the country. I rode with a unit of the Police Department in New York City one night, and watched the way that they worked with young people, and listened to the statistics of the kids that they had picked up. I did some little arithmetic in my head. I am sure this is not terribly accurate, but if their figures are accurate, there are more runaway children per proportion of the population in Galveston, Texas, where I worked than there are in New York City. Now, I know the problems seem overwhelming in these cities, but there are services in those cities.

Many of our rural children have absolutely nowhere to go when they are molested or when they are terribly hurt at home or when they are so depressed that suicide or doing something like that seems the only way to escape. There is very little except a big, wide world with trucks running up and down highways that they know can help them escape their pain. So I think as we look at the problems, certainly the AIDS infection seems to be centered, hopefully will not spread as much to the middle of the country as it has to our northeast corridor and California,

these children who are at risk and whose behaviors put them at risk are all across the country. So we need to extend our efforts to every little community of the United States, not only for our AIDS education, but because children should not have to live in the gutter.

DR. LILLY: One thing I would say to that, that while it was very much true in the earlier part of the AIDS epidemic, that cases were occurring in very specific portions of the country, if one follows year by year through the epidemic, the percentage of cases that are attributable to those early centers such as New York, San Francisco, Los Angeles, Miami, etc., is decreasing. So I would just like to make a slight correction that in fact you cannot escape AIDS by going to Ohio or Utah any more.

MS. PRICE: Well, there are a lot of shelters that are available. There are not very many street outreach programs for these kids. I am aware of probably between 15 and 20 programs nationwide. Because we have both a street outreach program and a drop-in program at the Bridge, in addition to offering shelter, we see a range of kids. We break kids into three categories for homeless. We have kids who are living in shelters, kids who are actually out on the street, and kids who fall into a category that we call dependent on friends. When you say where did you stay last night, they say, stayed with a friend. Where are you going tonight? Different friend. A lot of times these are the kids in prostitution who are staying with different tricks. What we have found is that less than 20 percent of the homeless kids that we work with are staying in the shelters so that there needs to be. An outreach effort to the kids that extends beyond just working with the kids in shelters to working with kids on the streets. It is very rare in this country that those services are available.

DR. SHALWITZ: In San Francisco, which probably would be considered to be quite wealthy in terms of its services to homeless and high risk youth, a kid cannot get into a bed for longer than 10 days. If you are feeling poorly, you are feeling bad, you really need a place, and, God forbid you need respite care because you are infected or because you have any other problem, it is 10 days max. There is tremendous effort on the statewide level and on every level to get some monies, to get legislation so that there is long term, safe housing. It is a huge problem.

Then, in San Francisco, again, where it is estimated that there are 1,000-2,000 kids on the street at any one time, there are no more than 30 beds for the kids so the problems are astronomical and again I talked about the crack crisis. There is no way I could stop talking about it. Its impact is just enormous, and one other thing that is interesting about San

Francisco is with everything that is going on and all of the wonderful behavior changes in a certain part of the population, there is not one county funded, local funded drug treatment slot for an adolescent, not a one. There is not one residential bed for an adolescent, you encourage them to get off of drugs, you encourage them to get clean and feel healthy and take care of yourself, they cannot get a bed for longer than 10 days, they cannot get a treatment slot. It is kind of like flapping in the breeze.

DR. LILLY: Even in my neighborhood in New York City, I am certainly aware of crack, it is there. Is it in Podunk Junction, in any tiny town?

DR. SHALWITZ: Yes.

MS. JOHNSON: Anecdotally? I grew up in a community in Indiana just north of Gary, a community of about 35,000 individuals with a lot of high risk young people, black and white and fairly ethnically diverse community, a lot of people there work in the steel mills and other industries, the few that are left, many people do not work there these days, especially young people. It is there. It is at least there. I can anecdotally tell you that I know it is there. I know that my nieces and nephews have friends who use it so it is there today and I am sure that it reaches into a lot of other parts of the Midwest and so-called heartland.

CHAIRMAN WATKINS: Ms. Pullen? Dr. Lee?

DR. LEE: When I first looked and heard your panel, I noticed how subdued you all were. It is such a staggering thing to have to work with that I can understand that it does some damage deep inside. Our Commission takes this issue that you are talking about very, very seriously. Probably the initial impetus to get into the problems with drugs came from our concern for the kids, for the HIV babies, and the fact that practically 100 percent of them are products of the drug industry.

Let me just reassure you a little bit about what we have done and what we are going to do. Ms. Price gave us some recommendations. Your first one was a clear federal policy on AIDS. Just this morning, Admiral Watkins has told the assembled group here that that is our primary function, to produce that, and we plan on doing that. Effective education efforts, this is probably our primary goal in what we are doing, is to ensure these education efforts. You say, recognize the contributing social problems. We have heard this, we have requested people and talked about this before.

You have certainly made more of an impression on me that any other panel I have heard. We are holding other hearings

in April on precisely those social problems that underlie drug abuse and the family disruption and the social disruption that is producing the maelstrom that AIDS has revealed to us. We have fears of getting a little bit outside of our AIDS mission, but as you unroof the boxes here, you just get into these terrible, terrible problems. I do not think a Presidential Commission ought to run away from them. Provide additional funds. Admiral Watkins has already been under a lot of criticism because he has asked for quite a package and undoubtedly there is going to be more to come.

Let me ask a couple of specific questions as you made so many terrific statements. One of them is the fact that these kids are running away from something. They are not running to the circus as you said. You gave a statistic, and I want to know what type of family they are running from. We are going to get into the family issues and I have had this predisposition that the family is probably very essential to solving the problem. We need the father back in the family. Now, on the other hand I am hearing from you people that it is the father that is beating up on everybody. What type of family, are they single parent families mainly they are running away from, is it mentally ill families, or is it abusive men in the families or is it total mixture?

DR. SHALWITZ: A, B, C, and D.

DR. LEE: The whole thing? I mean, in equal distribution.

DR. SHALWITZ: Well, some of them look pretty terrific too, on the outside. They look every single way a family could possibly look. They look well dressed, they look poorly dressed. Some are in mental institutions, some in drug treatment, some are just single parents, some are extended families. It comes in every color, every race, everything that you could possibly imagine.

MS. PRICE: Let me give you a little data on Bridge clients. We find that only about 20 percent of our clients come from an intact family.

DR. LEE: Come from what?

MS. PRICE: An intact family, and consistently 65 percent of the clients have one or both parents who are alcoholic or substance abusers. In a survey that we did of our clients, we asked them about physical abuse. Sixty-five percent of the clients said that they had been physically abused at home. Thirty percent refused to answer. I would like to say that very often a child who has been physically abused will keep that a secret and only five percent of our clients clearly stated that

there was no physical abuse in their family so it is all of these factors. Twenty-five percent of the kids in the survey reported that their family had significant mental health problems so all of them, to different degrees, are contributing to it.

DR. LEE: You have presented your information to this Congressional Subcommittee on the Family? Have they heard this? Obviously, they have heard this. They are concerned, this must be their main concern, and in a society like the United States of America, I just do not think there is a defense conceivable for allowing 1.2 to whatever million children to be wandering around in this kind of a situation. I can understand it in profound poverty. In this country, I cannot just imagine how anybody can defend it. We must solve this problem.

MS. BUCY: Yes, we have. Of course, the Subcommittee that has oversight of the runaway youth program also has oversight of child abuse and all the other programs, every one of which gets cut because domestic programs are not important or for whatever reason that our country has to let the deficit ride on the backs of children. I think you really have an important point there. Several of you have said you did not know these facts, you had not thought about these children, and it is difficult to understand why it can happen.

I believe that the American people simply do not realize how many children are getting ground up in the social problems of this country, and how many children are totally thrust out. We just have not let it penetrate our conscience. I have got this happy thought. If we ever did, they would respond appropriately. I do not think we believe in letting children live on the streets and eat out of garbage cans and have to prostitute in order to have someplace to sleep. If you could tell me how you get that word around, we could perhaps do a better job. But I just do not think people have snapped to it.

DR. LEE: Basically, we all are to blame here because this is a Congressional Committee. This is on both sides of the aisle we are allowing this thing to happen. I have nothing to lose so I am going to belly ache by telling them. What do you think about the fact that perhaps jobs are at the bottom of these destroyed families, no jobs, joblessness. Do you think that is a threat? Do you think that is something that is profound or do you think it is incidental?

MS. BUCY: Obviously, children are troubled in all strata of society but just as in everything else, people who are more affluent can access more resources to do something about it and when troubles come along, they have more places to turn. They can get psychiatric treatment for their children or hopefully for themselves because it has been my experience that most of the problems of these children are the problems of the

adults in the family and not primarily the problems of the children, although children who have been raised in crazy, chaotic families can get pretty crazy and chaotic. It takes very skilled adults to work with them and help them change those behaviors, but it can be done.

DR. LEE: Of the families, where does unemployment come in those families? Is it 70 or 80 percent of them?

MS. BUCY: A great many of them, particularly single mothers and with our minimum wage what it is today, a single mother can work even two jobs at minimum wage and she still does not get enough money to take care of more than one child. There is just no way that a person without education themselves and without the possibility for a good job, can work and provide for a family without some support system.

DR. LEE: Do you think jobs is at the bottom of it? A job for the man, will that put him back in the family, will that make him happier and stop beating up on everybody?

MS. PRICE: I think that contributes to it, but by no means is it the root of the problem. We have found a quarter of our kids that report that one or both of the parents work as professionals, and it is what is going on in the family. There also is a downward progression. It happens when there is a divorce in the family and there is not child support that is being paid or one or other of the parents who is drinking and you begin to see all of these other things begin to play in. There is also at the other extreme, we have a quarter of our kids that report that welfare was the primary source of income so I would not say that that is the root that you can trace it all to but it certainly is a contributing factor.

DR. JOHNSON: Dr. Lee, I see a link there that goes in two directions. We think about children and we think about them being out of school and we try to figure out how we can reach them. Well, we think about an alcoholic or an abusing parent and we think about that parent being out of employment. That is the same to me as school for a child. That is their linkage to the system, that is where they have peers, that is where they have a social support system. Whether it is counselling that is provided at the work place or whether it is going out with a buddy after work and talking about what has happened at home and frustrations, there is a social linkage there that is certainly very important, I think, to the fiber of mental health for members of a family.

And the other issue is obviously the economic connection and when you have economic stresses in a family, those stresses compound themselves into a lot of other behaviors which are very negative to the strength of a family.

DR. LEE: Mr. Chairman, I will finish now, in the interest of time, but I do not feel like it.

CHAIRMAN WATKINS: Are there any other important questions before I close out this panel because we are going to have to move along. I empathize with a number of points that have been raised here. I have been working now both within and without the Navy since I have retired in the whole area of connected versus unconnected youth, youth at risk and disadvantaged youth. In my wanderings around the nation, I have gone to a whole range of conferences on youth at risk sponsored by the National Governors' Association, Education Commission of the States. I have read the material from the Children's Defense Fund, many of your own organizations, studied it a great deal, worked on the Carnegie Council on it and many other organizations. One thing comes through clearly to me, and I think Ms. Patterson-Bucy touched on it, that we are not going to solve this problem unless we involve our young people with us. If we think we can dictate down all the time to them, and not involve them as part of the solution, I do not think we can do it.

They are the solution. They are the hope for us to get in there, and in every single instance where the unconnected youth has become connected again, to a person they will raise the hand and say it is okay for the adults to be there, we need that adult guidance but you had better get me one of my peers because that is what brought me back into the mainstream. In the Navy we had sailors helping sailors. They are called career counsellors because they could understand the language and they were right there with them, and they had been in trouble before and had come back into the mainstream.

It seems to me there is a mechanism here in the country that we are not tapping, the tremendous resource of our own people. In the schools, the encouragement and the incentive that can be given to those who have fallen out that we can bring back through our outreach programs and make them part of our peer mentoring, our counselling, our instruction, and it seems to me that we do not concentrate enough on it. We want to dictate policy from the top down, but we need to have young people involved. You said it yourself that we must get them involved with us.

Well, to what extent are we really getting them involved, and I am talking about the people who have faced the tough life and come back. We should grab hold of them as our key mentors to bring others back and certainly the reason that we were able to turn around attitudes and morale within the military was by this technique because sailors knew that they were the real solution and they were.

It seems to me we are not using our young people. If you have any ideas of how we might take advantage of where these intervention strategies have worked and perhaps try to get some kind of a national movement going with incentives, perhaps even at the Presidential award level, where people who have been outside with drug abuse or whatever can be role models. At Rich's Academy in Atlanta, a young, 16-year-old black girl sat next to me at lunch and had a 2-year-old boy. That is a pretty tough life but she had her act together now. She knew where she was going, she did not have a family. She had helpers out there and she had a lot of peer support in that Academy to pull her out. Why did we not provide the environment for her before the fact with peer support and peer pressure but being on the side of the individual, helping them.

It seems to me that we are missing an opportunity there, and there is a movement in the nation on youth community service that seems to me that fits perfectly with the organizations that you have and other non-profit and community based organizations. This kind of a movement can be started where we would have young people to be a part of the solution, not to do "make work" but to be part of the uplifting process among their own peers and bring more kids back into the mainstream. The Boston Compact, that is a classic example of good being tried out there. They know they are not as successful as they want to be with youth at risk.

There are other groups. There is the Community Service Project in Atlanta where for this year, the high school class of 1988, for the first time, must have 75 hours of community service. So much of it is going right back into youth service, helping others, helping other youth to come out of the morass of hopelessness and back into the mainstream. It seems to me there is an opportunity here and I would be interested if you would think about it. You are an unusual panel and you are right in an area of great intense personal interest on my own part. It seems to me that there is an opportunity here to explore that a little more, and I would like to receive a letter from each of you, if you would, thinking about this.

Beny Primm who is at our table here will talk about the intervention strategy for drug addicts and it often requires us to take that reformed addict and put them right back to work helping. The same with Alcoholics Anonymous. We have learned it before. Why do we not do it in the case of young people and get them back in with us in a big way?

MS. BUCY: I think that is a wonderful suggestion and I think most of us do that, most of us have young people on our boards to make the corporate decisions as well as the program decisions. I would like to affirm what you are saying about one more thing. In the 20 years that I have worked in these

programs, what has come through loud and clear to me is these kids are not deadbeats. Sometimes their families seem to be but the young people just do not let the world come raining down on their heads. They look around in this chaotic family and they say "This is not getting me anywhere. I want something out of my life." The young people who come to the shelters, who are looking for something better have a lot going for them and you can build on that, and they can share that strength with others. I would certainly agree with you that that may be the most underused resource that we have.

The difficulty, again is from the money point of view. To get youth participation programs, you need adult guides, and there has not been a whole lot of enthusiasm for that so I would certainly welcome your sanctioning that idea as a very, very valuable tool.

CHAIRMAN WATKINS: There are places in the country where it has worked beautifully in partnership. You go into a city like Rochester where you have a chief executive officer of a major firm like Xerox in David Kerns, and he will help bring that whole city alive. It takes a few leaders and their combination of excellence out there in leadership in certain areas of the country that can be role models for others. Indiana comes to mind. Indianapolis has one of the finest health fitness facilities in the world, certainly the best in the world, and they open their doors to all youth, disadvantaged and others where they have no other opportunities to come in under a strict regimen and they like that. They have some of the best community-based run community projects, youth service projects that are just starting now under an endowment by Lily and matching funds from the state and the cities. They started with business partnerships from the grass roots up, knowing that unless business gets in the middle of this and their corporate management gets involved, they cannot do it because they have to learn how to put their arms around these kids that have no families. We cannot beat on broken families when 60 percent of the 18-year-olds and under will only have one parent by the turn of the century. We have collected that demographic data, and we know what it is and we have got to deal with it.

Make it part of the development of all Americans, both in the academic side and the practical side, doing something useful for community and certainly getting these youngsters who, when they come back, are so turned on, far more than many of us who kind of slip through the normal process. Some of these kids really get fired up when they get back and will have a dedication for life to helping others. I think this Commission can help in that regard, to air the things that many in the nation do not understand or disbelieve it is not happening here. Would you be willing to send me a letter?

MS. PRICE: I would. Can I just respond for just one second? I will make it quick.

CHAIRMAN WATKINS: Yes.

MS. PRICE: All of our work that is successful with kids always utilizes the kids. There are some inherent problems, and I think that they never can be ignored and that is if we are using indigenous people or street kids, they still need to have a bed, they need food, they need support, and you do not get those things magically. They are our best resources so you need to help us get those beds and the food and the support that they need so that we can work with them and encourage them to be the real foot soldiers out there in the streets.

The second thing is for young people in the community to become a volunteer, I want to say again the streets are a dangerous place. It is very rugged out there, and I do not know how many people are going to feel so positively about their youngsters coming in to a very potentially dangerous place and we all value our youngsters. I know I do, and I might have some second thoughts about sending my pre-teen out there as well so I just wanted to make those comments.

CHAIRMAN WATKINS: I am talking about a concept of involvement in the solution to the problems that you have outlined. When you do not hear too much about the young people themselves being part of that solution, I begin to worry a little bit because young people who have come back into the mainstream invariably tell you that it was one of their peers that brought them back in. I am just saying that to throw it out on the basis of potential fear might turn off an opportunity here to turn attitudes around and involve young people in helping others. I believe you can get partnerships going in the nation and partnerships are coming alive. I think that when we get the American business leadership and industry totally involved in local community-based organizations and so forth, in a real spirited way because after all, even self interest would drive them in that direction.

So everything says it is the right time to move this direction, and so I encourage you to come forward to me with some specifics.

Thanks very much for coming to us today, and let us keep our dialogue open with you. You are a very talented panel, and you have given us some impressive insights today and to our country. Thanks a lot.

(Whereupon, at 12:15 p.m., a recess was taken until 1:15 p.m., the same day.)

AFTERNOON SESSION

CHAIRMAN WATKINS: Welcome. Our first panel this afternoon is on minority education, with the following speakers: Dr. Herbert Nickens, Director, Office of Minority Health, US Department of Health and Human Services; Fernando Oaxaca, President, Coronado Communications Corporation, Los Angeles, California and Ravinia Hayes-Cozier, Director, AIDS Education and Outreach Services, New York City Department of Health.

Welcome to the Commission, and I would like to start out then with Dr. Herbert Nickens for the first statement.

DR. NICKENS: Thank you. Chairman Watkins and members of the Commission, I appreciate the opportunity to testify before you today. The Office of Minority Health was created to oversee and to ensure the implementation of the report of the Secretary's Task Force on Black and Minority Health. That 1985 report provided the most exhaustive documentation ever done of the health status disparity in America between Asians, blacks, Hispanics, Native Americans as compared with the white population. An example: Of the 140,000 black Americans who on average die every year prior to age 70, about 59,000 or about 42 percent would not die if black Americans had the same death rates as the white population. As a generalization, minority Americans die from the same causes as do white Americans only more so. About 80 percent of the excess deaths among minorities come from just six causes, cancer, cardiovascular disease and stroke, chemical dependency, diabetes, infant mortality and violence.

The full Task Force report runs about 3000 pages. The magnitude of the minority health problem detailed by the report, as well as the large number of recommendations it contained made it clear that some implementing mechanism was required. The Office of Minority Health or OMH, as we call it was created in December 1985. For a variety of reasons, the Task Force report did not include a discussion of AIDS. However, soon after the office was organized, the data made it clear that AIDS must be added to the other six causes of death with which OMH is concerned. However, from our perspective, AIDS is but one of a cluster of severe health challenges that confront minority Americans. In general the problem of minority health is often seen solely from two extreme perspectives, one too narrow, the other too broad. Too narrowly, minority health is sometimes seen as a product of too little access to health care. At the other extreme, minority health is often seen too broadly as primarily a product of poverty, therefore, only amenable to economic solutions. Both extremes contain some portion of the truth.

In the Office of Minority Health we believe that health education in empowering minority communities around the issue of health can both amplify the salutary effects of the health care system, as well as blunt the effects of poverty. In order to achieve this, we believe that direct funding of community-based organizations with technical assistance, as appropriate, is a powerful tool to improve minority health. AIDS, albeit in a compressed time frame, presents similar challenges and requires similar solutions as do the other so-called "big six" causes of death. More information regarding OMH's programs can be found in the written testimony I submitted earlier.

Specifically with regard to the topic of this panel, AIDS and minority education, I would like to conclude with the following comments. Given the time urgency and the complexity of HIV infection among minorities, a nationally coordinate, multipronged minority AIDS education strategy is required. That strategy should include the following considerations. One, as you know, minorities are disproportionately represented among persons with AIDS. Moreover, overwhelmingly, AIDS among whites occurs among homosexual or bisexual males.

On the other hand, among minorities homosexual and bisexual males represent only a plurality of current AIDS cases. Transmission through the sharing of needles and works and heterosexual spread are, also, very significant. As a result, among minorities, AIDS is, also, a disease of families: men, women and children. Therefore, the behavior change challenge required for effective prevention is by orders of magnitude more complex.

No. 2, a national minority AIDS prevention strategy should utilize the analytic and communicative techniques developed by the advertising industry, including, but not limited to, identification of and research on market segments which include variables, such as race, ethnicity, language preference, age, sex and HIV transmission risk groups.

No. 3, indigenous minority institutions and leaders are essential to credible communications and must be empowered and trained regarding health in general and HIV infection in particular. Examples of such institutions are churches, schools, fraternal organization, as well as community-based and national minority organizations of other types.

No. 4, more traditional public health related agencies and organizations, for example, public health departments, hospitals, health professionals and voluntary organizations must be encouraged to become full partners with those others described above.

Fifth, and last, particular attention must be paid to achieving behavior change among intravenous drug abusers and their sexual partners. Otherwise without an effective treatment or vaccine, this group could provide a permanent HIV reservoir.

Though health services are not the subject of this testimony, many of the same organizations and efforts described above must, also, be enlisted and empowered if a rational and humane HIV infection service delivery system which effectively serves minority populations is to be constructed.

Finally, in a sense, AIDS presents us with both a crisis and an opportunity. A service and prevention infrastructure must be created in response to the crisis of AIDS among minorities. America should avail itself of the opportunity to utilize this infrastructure to attack all of the diseases that create excess mortality and morbidity among minority Americans. Thank you.

CHAIRMAN WATKINS: Thank you very much, Dr. Nickens.

Mr. Oaxaca?

MR. OAXACA: Thank you, Mr. Chairman. I, too, welcome the opportunity to be here this afternoon with you and the rest of the Commission. I was cautioned several times by your staff to try to keep my remarks to 5 minutes. I will try dutifully. I hope it is not an expression of the importance of the subject we are trying to cover because I think in particular the Hispanic community, with its language problems in many parts of the country and certainly even its cultural separation within the immigrant portion of the community makes learning about AIDS and the other issues associated with that is a very, very difficult process indeed.

I happen to be in the media business, as well as in the communications business in general and currently am running the program for the Department of Justice on informing the American public about the new immigration law. Part of that involves trying to communicate to aliens who are here illegally how to apply for amnesty. That is almost as difficult a job perhaps as informing people about something as complex as AIDS, convincing individuals that they should trust the government, that they should trust authorities who have in the past pursued them and let them now confront that government in seeking to change their status. The only reason I mention that is I see many analogies between that and the communications problem and what faces our country in the AIDS arena. I think one of the biggest lacks that we feel exists, also, is research not in the classic sense of understanding the disease or what can cure it, hopefully, someday, but I am talking again with regard to communication. We don't know what we don't know in the Hispanic community, and I suspect in the Asian community and a lot of

other groups that are a little more distant from main street communication.

We break up like many other parts of our society, different economic levels, educational attainment, but we add the complexity of how long people have been in the country, how well they know the English language. It creates subsets of our part of American society that know about the problem at different levels. In fact, the very beautiful papers by both of my colleagues here, highlight that the minority community is the least educated, the least knowledgeable about the problem that we are talking about. Therefore, the educational process is just double or triple the complexity.

The main thing that I want to appeal today is that there is still an opportunity for prevention in a lot of elements in our society. There is still an opportunity to educate people, and we have the horrible task of finding a cure, of scientific solutions. I am only saying, "Let us not forget about the educational and communication problem that faces us," and we are going to have to spend some money to do it.

I suggest that maybe a few hundred thousand dollars can do that research to find out how much is known by people so that then you can design the advertising program, the public relations program that it would take to reach these communities. I want to stress that the old approach of public service announcements and "freebies" in other words, appearing on NBC or CBS or ABC, that will not do it in this case. We need to get to ethnic media. We need to get to small radio stations. We need to get to the Spanish language television nets. We have to get to the little weeklies that barely survive every day, every week to communicate to these communities. That is how these people find out what is going on, and you are going to have to pay for it. I am suggesting that within a trillion dollar national budget or a billion or two billion dollar AIDS budget that somehow you could find 30 or 40 or 50 million dollars to initiate this kind of communication program with bought, purchased advertising and to begin addressing this educational task on a credible basis. The things that Dr. Nickens talked about in terms of using credible spokespersons from the community, all the various things are absolutely true. You have to buy your way into it. You are not going to get it with freebies. The private sector is not going to move out and do it on its own. They don't see an incentive at this stage. I think once they are educated themselves, your companies, your corporations that hire a lot of these people will probably play in the game, but you are going to have to show some leadership at the federal level. Perhaps you will get some leadership at the state level, but nothing is going to happen in and of itself, and all the academicians and all the researchers crying about the issue will not move the system until somewhere, somehow some real money is put together and is spent.

That is sort of a summary, really, of how I feel about the situation. I have discussed what I was going to say today with people in television and radio and print across the United States.

I think there is a consensus out there. I have, also, talked to some of my black colleagues in the communications business. They all feel the same way, that it is tough, it is difficult, and it is going to take money. It isn't going to be done on a charity basis, and that is what will have to be faced. Thank you, Mr. Chairman.

CHAIRMAN WATKINS: Thank you very much, Mr. Oaxaca.

Ms. Hayes-Cozier?

MS. HAYES-COZIER: I, too, like my other two colleagues appreciate the opportunity to speak before the Commission on what I and many others have learned about a battle that sometimes seemed insurmountable, and that is the battle for education in the area of AIDS.

Every day the AIDS epidemic thrusts itself on a new, broader and more diverse cross section of the American society, but nowhere has it had an impact more acutely than among the minority population. It is for this reason that I will focus my remarks on an area of the epidemic that is unreported and oftentimes misrepresented, and that is AIDS education and prevention in the minority community.

While much has been done to educate the public about the spread of AIDS, educating the minority community has been at best akin to shooting an arrow at an undetermined target. To fully understand the impact of AIDS upon the minority community, you must first understand the community. These communities are seized disproportionately with problems such as poverty, crime and of course, something that you all have heard and continued to hear, substance abuse.

In areas like Central Harlem in New York City, where infant mortality is as high as some Third World countries, and 90 percent of all prison inmates are black and Hispanic, many communities view AIDS as just another issue to those that have already overwhelmed them. These problems, although well documented continue to be inadequately addressed and therefore contribute to and compound the disproportionate impact of AIDS upon minorities. Therefore, let us take a few minutes to talk about and concentrate on some of the variables that prevent the kind of education that needs to be applied in the minority community. Potential barriers for educating the minority community pose an even greater threat than the disease. We must pay close attention to current efforts and the problems

associated with messages that are not being understood by the community. In order to comprehend the impact of those barriers, we must first identify them.

Sexuality. While it is difficult for society to confront the issues of sexuality, it is further complicated by the denial in the minority community that homosexuality or bisexuality actually exists. Many community people have the illusion that they are able to identify the one gay black or Hispanic on the block, when in fact, just as with the IV drug user, the appearance of this individual takes so many forms, from the stereotyped to the three-piece suit, from the uneducated to the educated, to the doctor or lawyer. This makes this group of individuals even harder to reach because of fear of isolation and condemnation from family and community.

The intravenous drug user. Drug use has always plagued the minority community, and it has always been the top layer of all of its ills. This has caused the community to respond in several ways as it relates to the IV drug user. Don't bother; they won't change. Sterilize all childbearing females who are IV drug users. We know what they look like. Let us round them up and get rid of them. So, any educational message must take into account the psychological and the physical state of the drug user, as well as the mood of the community.

Many minority communities have been vehemently opposed to any educational effort that has the appearance of endorsing any type of drug use, even though educating the addict about cleaning his works or exchanging his dirty needles for clean ones has slowed the rate of transmission of HIV infection from addict to addict and from addict to sexual partner.

Let us focus our attention on religion. While many religious leaders agree that AIDS must be talked about in the church, not all agree on how and what should be said. This is particularly important when addressing the minority community because the church has always been a beacon in a sea of despair for the minority community. It has been the voice in which people have learned, understood and reacted to when problems facing the community have arisen. The religious community's response to the minority community about the AIDS epidemic has sometimes been helpful, sometimes been confusing and sometimes been moralistic.

For example, many religious leaders are more than willing to talk about abstinence and monogamy but refuse even to mention homosexuality or condoms. Other leaders will educate their parishioners about everything, while some will condemn those behaviors that they view as morally wrong. Unfortunately,

the church has not taken the lead in educating the minority community as they did in the past concerning other issues.

Educating women poses some interesting problems. Many are not aware of their sexual partner's involvement in bisexual or IV drug-related activity, thus putting them at a greater risk for HIV infection.

Also, initiating new behaviors, safer sex, is often difficult to accomplish without one's partner becoming suspicious or not willing to go along with the request for condom use or other behavioral change. As a result of these limitations, educational efforts have been met with denial, fear, indifference, and we must begin to develop strategies to help women incorporate new behaviors in their relationships.

Community-based organizations. Minority community groups while well intended are overwhelmed with many other problems that confront their communities, and AIDS just becomes one more problem. The community-based programs are willing to do one-time program but without sufficient funds are unable to continue ongoing education programs.

Minority leadership. Another area of which we should become acutely aware, minority leadership has been slow to address the issue of AIDS. One might say that no one wants to be the first one on the block to deem AIDS as a minority problem. These leaders fear that once AIDS is considered a minority problem funds will dry up, and talk of quarantine will begin.

AIDS brings with it many social agendas, and because of the stigma associated with homosexuality and IV drug use, many leaders feel that to address this openly and vocally raises questions about their own behavior and may put them in jeopardy with their constituents.

Last in the area of barriers, minority media have failed to respond to the crisis. While agencies like Mingo Jones, a black advertising firm and some other minority media, print and broadcast, have addressed AIDS in the minority community in a responsible manner, others like Chocolate Singles refuse to believe that their clientele could possibly be at risk for HIV infection, thereby confusing their readership about transmission due to people as opposed to behavior that put them at risk.

AIDS has brought out natural fears and anxieties that have led to a pattern of harsh discrimination against minority people. You might ask what needs to be done, and I think I concur with my other two colleagues, that nothing short of a national strategy that includes funding, that is available for

community-based organization who are already servicing minority populations must be put into place. A national education and prevention strategy aimed at minorities must be directed and must show more than an IV drug user putting needles into his arm. It must show more than a white family walking into the sunset, and it must show the many faces of AIDS.

Outreach programs must be funded because those are the grassroots of the communities who can march through and reach people more directly. Research by minority researchers must be put in place because they come with an understanding of the culture and the values of the communities. Minority leadership must take a stronger stance, and community-based organizations must get technical and training assistance in order to incorporate concrete, clear programs in an ongoing basis.

In closing the societal trend of losing two generations has appalling implications for the minority community. AIDS raises questions of responsibility that must be addressed at every level, federal, state and local government, as well as the community at large. If we fail to meet the challenge of AIDS today, and let me say that again, if we fail to meet the challenge of AIDS today, there will be no need for minorities to plan for tomorrow. Thank you.

CHAIRMAN WATKINS: Thank you very much, Ms. Hayes-Cozier. I would like to start. I think Mr. Creedon may have to leave. John, if you will start the questioning?

MR. CREEDON: I agree with you that the characteristics of the minority community are probably such that AIDS needs special attention. I guess one of the questions I would have is what would be the vehicle for making sure that everything that should happen does happen; Dr. Nickens, is it your office or is there some other organization that we should be looking to? If this is to happen, who is going to make it happen? Who will have the responsibility for making it happen?

DR. NICKENS: If you are asking about where in the federal system would the organizing entity be, if that is your question --

MR. CREEDON: I am not sure whether it is in the federal system or outside of the federal system. I guess the question is what would be the most effective organization to do the job that needs to be done? Is it a unit of the Federal Government? Can the Federal Government coordinate with the state and local community-based organizations effectively? Is it doing it now? If it isn't, why isn't it? Why isn't more being done than is being done?

DR. NICKENS: I think that first of all, AIDS presents us both with regard to other minority issues and with regard to AIDS itself- a challenge that we have never really addressed before, and that is how do you organize a systematic national health campaign to improve the status of minority health? I don't think that has ever existed. So, that is No. 1. We are breaking new ground here, and this disease may make us break it. Regarding the question of what organizational entity, I think it needs to be an entity that represents the federal establishment, and the Federal Government is well positioned in many ways to perhaps be the organizing entity, but it certainly needs to include representatives of all the other sectors in our society that are relevant, and that includes state and local government, of course, but all the other private sector parts.

Now, that is the organizing part of it. The question of the implementors, I think the implementors need to be even more varied, and I think that if you ask yourself the question, how would you sell the various messages that need to be sold that may result in behavior change to minority Americans as diverse and complex as they are I think you come up with a number of entities that probably numbers in the thousands and media that are multiple, so that you are talking about a very complex operation. Unfortunately, it is the only choice we have, so that you are talking about everything from television to person-to-person contact to church contact and so forth.

MR. CREEDON: Does your budget for 1988 and 1989, contemplate the necessity of doing this? Is the level of funds adequate to do what we are talking about here?

DR. NICKENS: The Office of Minority Health has just recently officially gotten into the AIDS business, and I think that we certainly -- our mission in the Public Health Service and in the Department is really to be an advocate and a coordinator and to do some innovative programming. I don't think at current levels we are organized to do what needs to be done.

MR. CREEDON: It seems to me it would be helpful to the Commission if you, maybe three could get together and make specific recommendations as to what we could do to help you get the job done, and especially you, Dr. Nickens, where I think that the natural place for coordinating activities would probably be you. Do you have enough money and help or whatever else is necessary? One of the difficulties, it seems to me, is overlap. We will be dealing with drug abuse problems in certain ways with certain agencies, and you don't want too many people dealing with the same issue, and yet there is the inevitable overlap here.

I think the minority problem is apart, because of the language barrier primarily. We, Metropolitan Life Insurance Company, did have a program last year for the AIDS awareness test which was a 2-hour television program. We did translate it into Spanish, and it was shown, but I don't know whether it penetrated at all.

We are doing a series now with Westinghouse TV, and we are going to do that in Spanish, too, but I don't know. As you said, "We still have the Chinese communities, and we have other communities that are involved," and how you reach them, it seems to me that you do have to have something that is specifically looking at that subject and has the adequate funding to do the job.

CHAIRMAN WATKINS: Dr. Primm has to leave here shortly for a Drug-Free American Council Meeting. So, I will ask Dr. Primm to go next.

DR. PRIMM: Thank you, Mr. Chairman. If I remember, your office was established primarily to look at some of the problems that face minority America that were pointed out in Secretary Heckler's report. They were specifically cardiovascular disease, if I recall correctly, stroke, chemical dependence, diabetes, homicide, suicide, drug abuse, unintentional injuries and infant mortality. So, I would imagine that you taking on the task to do something with AIDS would fall under, I guess, unintentional injuries or whatever, Currently your budget is a very small one, if I recall, and that was to include Asians, Pacific Islanders, Native Americans, Hispanics and blacks in this nation and that you had a budget of $3 million to do so. Now, superimposed on your task of course, is to take care of the problems of AIDS, education on AIDS in the minority community.

I am wondering how in the world you are able to function with that meager amount of dollars that has been allocated for your office under your aegis to do something about this problem along with all the others? In your investigation of your initial mission in these areas I am sure you have uncovered a number of things in communities which you are destined to serve and have found that the ground is very fertile in some of them for infection with this virus.

I would like you to comment on that and comment on the stress and the immunosuppressive nature of the environment itself as it predisposes to infection with this virus which perhaps explains some of the disproportionate representation of these minority groups with the problem of human immunodeficiency virus infection and AIDS itself.

DR. NICKENS: I will go back to your first comment first and then come back. I think that the office was set up really as a coordinating office, and so that was the reason why it was designed as a small office to utilize the rest of the Public Health Service and HHS in a sense to try to influence how those entities spend their dollars and design their programs. We have been appropriated another million and one-half dollars in Fiscal Year 1988 to do specifically AIDS. So, we do have an AIDS budget, and that was what I was alluding to earlier, about we are now officially in the AIDS business.

I think that as far as how we do what we do, I think part of it is we have a very motivated staff, and I think that that has enabled us to try to keep up with lots of things that we do have to keep up with, but I think it is important to understand that we weren't designed to implement the report but to make sure that it gets implemented.

Now, as far as the final question you raised, I think that the question you asked in a sense is almost at the frontiers of science about the impact of stress and status of minority immune systems, if you will. I think that I don't know, and I don't know if anyone knows for sure what specific kinds of susceptibilities other issues may create regarding HIV infection. Clearly the most dangerous circumstance that makes minority communities fertile grounds is a combination of the multiple transmission route,(intravenous drug abuse being the most distinctive, in addition to homosexual, bisexual transmission, and heterosexual transmission), but combined, with a kind of isolation that is part of minority status. This isolation means that information, even if it is beamed over the television, may not be believed; that no one wants to believe that they are susceptible to AIDS after all, so that to the degree that messages appear somewhat alien that the English may be formal; that the English may, in fact, not be Spanish or one's native or preferred language; all these things enable people to avoid feeling at risk for this disease, and of course, that is lethal.

CHAIRMAN WATKINS: Yes?

MR. OAXACA: I will address the whole Commission. You know, I think special problems call for special solutions, and I would suggest that the Commission might consider recommending to the President that somewhere within HHS that a central interagency task force be established for that period of time it is necessary, and that it be charged with this single role of public education and information about the HIV epidemic and AIDS. I understand that the National Centers for Disease Control in Atlanta has spent money with a major Madison Avenue advertising firm. There is something going on there that I am sure is not your office, necessarily, and that may be very, very

fine. They are creating PSA's. Who knows what else may be going on in that giant thing called HHS, but I think this is a special kind of problem. It requires some very fast action, and I think such an office; it happens all the time in our marvelous government. I spent 2 years here with the Ford Administration, and I know how things can be done if you have to do it, with funding, with special direction. I think an advisory board or some kind of ongoing contact with representatives from the various elements of the minority or the ethnic communities in the United States so that there can be a linkage. The implementing mechanism is going to have to be twofold, it seems to me, in the main. It is the mass media that currently serves the minority community. Some ought to be in English and a lot of it in other languages, tightly working with your community-based organizations, your activities at the grassroots. Your Chinese or your Korean is not going to listen to anybody other than a Chinese or a Korean. The Mexican in Texas needs to be served differently than the Puerto Rican in New York, and I have a feeling that the blacks in the Northeast have different media habits. They are reached in different ways and perhaps with slightly different messages than they might be in the Deep South. These are things that are going to have to be all considered in trying to communicate, and you cannot have a monolithic approach to this problem.

DR. PRIMM: Ms. Cozier, you finished your testimony and left the Commission on a very somber note and repeated it twice, and it predicted some doom for young blacks or minorities here in this nation if something is not immediately done. You serve New York City, I know, as Director of Education in the New York City Department of Health. What do you feel that this Commission could recommend that would make your life a lot easier and make you change your very pessimistic ending to an optimistic one? I would like, also, to have that kind of answer from you, Dr. Nickens, if that is possible, and certainly if you would suggest to me either today or through the Chairman some of those things that I could do personally to make things better for minorities in this country. I would like to do so. So, if you would, I would appreciate that.

MS. HAYES-COZIER: At a governmental level, I think that is something that we all concur with, that it has to be a strategy that is well thought out and that for once in life different components of the Federal Government need to talk to one another. The kind of thing that was just mentioned that one program is not implemented where another program is implemented with no kind of end thought to what is going to happen in behavioral change, and that is what we are working towards, any educational effort to work towards changing behavior. On the community level, I think it is clear that that is going to have to be our direct contact through the community.

Funding must be put in place, but more so than throwing money at community-based organizations. We must provide them with technical assistance and training so that after AIDS those programs continue to exist, and they continue to be able to provide clear health care services, as well as educational messages that are going to translate to behavior change in the community. Unless that is done, no matter, we can do it piecemeal, but we still don't know what kind of impact or in some sense maybe we do know what kind of impact that we are having, and that is not in terms of getting people to move from learning about something and changing their behavior.

DR. PRIMM: You said something extremely optimistic in your response just then. You said, "Clearly after AIDS. You must be looking at some crystal ball quite different from the one I am looking at. I think AIDS will be around for a very long time. In the previous panel there is no question about it that one of the panelists talked about the longevity of the disease entity. So, I think we are going to be faced with it for quite a while. Dr. Nickens?

DR. NICKENS: I agree with what has been said, and, also, I feel very worried about the future as well. The diabolical nature of this virus makes us all get lulled. Because of the latency period the seeds of disaster can be sown and not show for so long. The seropositivity rates in addicts and especially in places like New York City are a good example of how you can have a population essentially saturated before you realize what is happening. So, I am very concerned as well. I think as far as the issue of how we can organize this, I think that one of the key points that is really important is that we need to find a way to get more minority input into programs. The idea of a strategy is critical, but there are sensitivities. There are awarenesses. There is, also, the willingness to take certain risks that minorities have as a part of culture and a part of life experience, and I think those minorities need to be both in the federal leadership, that is minority federal leaders but, also, non-federal, state, local, outside citizens, everyone. I think that we need a cross section of opinion because otherwise we are not going to go to the targets, and time is of the essence. This is a critical consideration in whatever this coordinating entity that gets set up has.

DR. PRIMM: Thank you very much.

CHAIRMAN WATKINS: Ms. Gebbie?

DR. NICKENS: I just want to add that that is not an affirmative action statement, by the way. That is a statement of pragmatism. That is the way the job will get done and not because I am concerned in this context about having goals and timetables for minorities in this particular structure.

CHAIRMAN WATKINS: Thank you. We will shift back to our left to right. Ms. Gebbie is next.

MS. GEBBIE: I am finding in your presentation one of the clearer examples of what I see as a continuous issue that has come before us many, many times. That is, the tension between doing something on a national scale that will accomplish whatever it is you are doing, clearly directed, focused, do it once, do it right kind of thing and then the do it locally, do it uniquely, make it ours, we have to do it here so it will really speak to the people involved which, also, has a ring to it that makes a lot of sense. I have heard things, from each of the three of you that has some sense of both of those concepts, and I would appreciate some additional comments on that area with particular attention to education because that is what we are looking at today. How to get the knowledge for behavior change to each member of every minority group in this country. Would we be better advised to create the kind of central body that Mr. Oaxaca mentioned with a huge budget, an even bigger budget to an even bigger Madison Avenue firm, saying that you have got to produce 500 ads, one for every minority group that could be put on page space or whether we would be better off taking that same amount of resource and pumping it out and saying, "You all have the facts. Here is a resource. Do it yourself at a state or county or city level somewhere." I really would appreciate more discussion of the relative importance or appropriateness of those two alternatives or a mix.

MS. HAYES-COZIER: I truly think that it is a mix, and I think what needs to happen on a national level is somewhat the educational awareness clear message that is culturally relevant. I think in terms of actually helping people demonstrate behavior change, this is going to have to happen on a community level, and that is where people have access to people, where people can not only hear about how this virus is transmitted but, also, how they can take time to practice and incorporate those behaviors that they need to learn in order to put them at a less risk for HIV infection. That is going to have to happen on a community-based organization level where people can practice those behaviors in their community, get involved in working with the community-based organization on a long-term basis because those behavior changes are not going to happen with just one program given by a community-based organization or one ad put on a TV. It is going to have to be over a period of time, and it is a process, one that they have to feel comfortable with, and people feel comfortable in their own environment

DR. NICKENS: I think that one of the issues is the question of delegating power. I think that if you perceive a national strategy where all the power is held tightly in the central organization, then it will fail. I think what you have to do is to have a coordinating mechanism at the national level.

Some of the funds will obviously come from the national level but, also, a sharing of power down the line so that local organizations, also, have a sense of having some control, whether it is factoring local tastes and sensibilities into programs, or whatever. So, decisions can be made at various points. I think an analogy, also, may be drawn from advertising campaigns. When you have a national advertising campaign, you see the image on your television set, and I think that a key part of our nation now is that we are all linked together by this thing called television. But you see an image on your television set. And then you walk into your local drug store, and there is a cardboard cutout of the same image with pamphlets in its hand. There is a link there, if you will, between the national and the very, very local, that we are capable of doing in our society, but it is complex. It is not easy to do, but I think it can be done and is necessary to get the best of both, as you pointed out.

MR. OAXACA: I think there is another very critical aspect. When we say, "Education," we have to recognize that in some elements of our minority communities, it is literally a blank blackboard we are looking at, a tabula rosa. They don't know what AIDS is all about. You are starting from the level of zero. There are other places where there is greater knowledge, more sophistication, where there is more language affinity. Maybe you have as good an understanding as mainstream Americans, and so, when you have got this incredible diversity of a generally uneducated public within the minority communities, you have got to tailor at the local level. But, I think that a national program, in particular, lends itself to at least building a general awareness of the hazards, of the dangers, of the processes for transmission of the disease. There is a certain level where I think you can set some efficient processes for communication. Eventually we mustn't confuse education for sheer awareness and education for the next level of prevention and as she points out so aptly that is behavioral change. That is a different communication problem, and what I am saying is that unfortunately, we are still very much at ground zero, and we have not even made that first penetration in general awareness of the issue.

MS. GEBBIE: My second question, and that is a wonderful lead in to it, actually, is that we have heard over and over that it is hard to get people to work on a problem they don't know, and one of you pointed out this issue that although HIV infection has disproportionately infected minority communities, there is a reluctance to own it because it is seen then as leading to some other undesirable ends, further discrimination or isolation. Any insight the three of you could offer to how to accomplish ownership that turns out not to be destructive I think would be very helpful.

DR. NICKENS: We struggled with that problem in the office when we started thinking about how to start to help this issue along. First of all we brought in a group of advisers, people on the frontlines working against AIDS, in a small quiet advisory meeting. That was in April or so of last year. In June of last year, with the CDC, we cosponsored a Minority Leadership Forum on AIDS which had about 40 national minority organizations sitting around the table with Public Health Service officials and some people in the frontlines against AIDS as well. That was a more visible meeting but still quiet. Those organizations clearly said "yes, we own this problem, and we are willing to say that this is our problem". In fact, many raised their hands and were already involved with AIDS programs. So, I think that going to leadership, and starting to get people engaged, and again, empowering them around the issue which does work.

I think it is a slow process. It requires sensitivity but it can be done, and much of that groundwork has already been laid. I think clearly the time is ripe, if you will, and many minority leaders have already publically said, "This is our problem," and I think we need to diffuse that to the local level, but I think the ground is fertile. I don't think that will be a real problem.

MS. GEBBIE: That is encouraging.

CHAIRMAN WATKINS: Dr. Lilly?

DR. LILLY: I just wanted to address myself briefly to one aspect of what you have been talking about. I think you have done a wonderful job of putting the problem of minority education into perspective. I would simply like to comment on what I would call the individuals with dual passports, shall we say that I have been involved with in the past. As some of you may know, I was on the board of the Gay Men's Health Crisis for some time. There in attempting to educate the gay population, we found that, indeed, we could get fairly successfully to that portion of the gay population that was black, but that we were not at all good at getting to that portion of the black population that was gay, if you will allow me to make that distinction. The best that we could do was to offer our services to train people who did know how to communicate with that community because we simply did not speak the language, and they didn't understand ours. So, I hope that will reinforce the message that you particularly brought out. Thank you.

MS. HAYES-COZIER: I think that is well taken, about the black community. One of the things that continues to amaze me is that when we talk about the conduit of this infection into the minority community, we talk about the IV drug user. I sat down the other day, and I started to look at New York City's statistics on cases that we had, and to my amazement in the black

population, the male population, we had over 1500 cases that were either gay or bisexual men. In the black male population we had approximately 1300 or close to 1400 cases that were IV drug users. That is something that is rarely, if at all ever brought out so that the community is left with the illusion that the only conduit into the minority community is through the IV drug user. We have got to start to face up to the fact that we, also, have the gay and bisexual population that exists among minorities, as well.

DR. NICKENS: I think the larger issue though that you are raising is that clearly you cannot use definitions across the board, and so there is going to be a different interpretation. For example, what it means to be homosexual or bisexual in different cultural contexts may be different, but the virus doesn't care. The only point is change behaviors and get people to understand what behaviors are high risk, it matters not whether or not they declare themselves in some particular way. I think that that is something we have to wrestle with because we all have notions of what it means to be in one category or another. I think we have to throw that out. That is what ownership, and minority groups controlling the problem really means. Then the issue gets defined in the way that works.

CHAIRMAN WATKINS: Dr. Lee?

DR. LEE: I wanted to call on Paula Van Ness. She walked out of here. Is there somebody else to ask questions? I hope she comes back. She said that she was going to come back in 5 minutes.

CHAIRMAN WATKINS: Dr. Walsh?

DR. WALSH: I don't have any questions, only the comment that your testimony, along with the testimony of previous panels has emphasized once again that AIDS has drawn a great deal of attention that this is not purely a health problem. It is a societal problem, just like IV drug abuse is a societal problem, just like long-term care for the elderly is a societal problem. I think we are in a whole new era with AIDS as a way of taking a look at our health care delivery system and where this can emphasize both its weaknesses and its strengths. The comments that are brought up consistently particularly in the recent period just emphasized this to me a great deal, and I think have made our task even more difficult. We appreciate your bringing these to our attention. I just don't have any questions. You have all been very clear.

CHAIRMAN WATKINS: Dr. Crenshaw?

DR. CRENSHAW: Did you want to say something?

CHAIRMAN WATKINS: Please, Mr. Oaxaca?

MR. OAXACA: If I might, Admiral. On a somewhat positive note, in my experience, being in the advertising, public relations business and media business in general, what I find in the minority community, once it is educated, once it is knowledgeable of a problem, of an issue, it is responsive, and in some ways more responsive than mainstream America. They are not as jaded by so many people romancing them. They don't have as many media outlets chasing them, and if we can get the message to them, I think they will respond, perhaps in greater measure than most people who are just sick and tired of the commercials and radio and television blaring at them all day and all night. And so, in a way that is an important aspect of this, that if we can get clear messages as Ravinia talks about, if we can communicate these very complex kinds of potential situations to not only that 15 or 20 percent that may be gay or bisexual, and I don't know what the percentages are. In our Hispanic community we now have 80 percent that are at risk, and once that is understood, there will be a response, I assure you.

CHAIRMAN WATKINS: Dr. Crenshaw?

DR. CRENSHAW: I would just like to comment, again, after thanking you for being here and sharing your views with us that we seem as a society to have a repetitive pattern of allowing minority groups or ethnic groups to be the previews of disasters to come, and often not responding rapidly enough. One of the few positives hopefully of this AIDS epidemic will be that we cannot afford to wait and watch, and must look at any of the communities that are less disadvantaged than others as so much a part of our society that we respond in time because I don't think we have got a real good track record of doing that. Thank you.

CHAIRMAN WATKINS: I will open it up for follow-up questions?

DR. LEE: May I slip in here now? Originally when this Commission was put together, one of our ideas was an advisory committee of PR people and press and media to try to do some sort of organized program of the type that Mr. Oaxaca has been talking about. This was put on hold because there was disagreement about our particular role in that regard, but we have Paula Van Ness here with us is Director of AIDS Information and Educational Programs at the Centers for Disease Control. She has listened to you. I wonder if Ms. Van Ness has any comments on how this type of thing could be organized and put together, and do you agree that some money has to be committed because people this morning told us the exact opposite. Would you like to say a word?

CHAIRMAN WATKINS: Could you come up to the panel table so that we can record the comments, please, Ms. Van Ness?

Ms. Paula Van Ness, Director of AIDS Information Education Program, Centers for Disease Control.

MS. VAN NESS: Thank you. I do have some thoughts on the subject, much in a way to echo what the panelists have been saying during this time. The use of the media is an important adjunct to what we are doing at the community level, but where real behavior change takes place is at that local level where there are the kinds of interactions that media programs support.

We have been making a very strong attempt to address minority concerns through our work in the media in developing special materials. By no means have we done a complete job, and there is a great deal more to be done. I think your idea of convening a panel of experts is one that we have found to be very helpful. We have tapped into some of the great geniuses of our day in terms of use of the media, looking at campaign strategies, looking at ways that we can develop materials that will have an impact. We are committed to continuing to do that, and I don't know that there is a necessity for convening another kind of panel as you are speaking about.

DR. LEE: If CDC is willing to function in a sense that is satisfactory to these people, and June Osborne even brought up the TV theme, "Be all that you can be," and there are some very inventive minds out there, certainly in the advertising world. I would, personally, sure like to see somebody pull it off.

MS. VAN NESS: We see it as our charge. We are doing what we can do within the limits of our resources. I can guarantee you that there is more that we can do, but to do more requires more resources. We stand ready to increase our effort and to continue to tap into the creative kinds of genius and the technical knowledge that people have throughout ethnic minority communities and community-based organizations that service other specialized populations in order to make this work.

DR. LEE: For the community that Ms. Hayes-Cozier has talked about, it seems to me you could reach some of these kids and so forth with some beautiful types of spots on an intensive national basis that would be very specific. Do you have anything to contribute to that, sir?

MR. OAXACA: I would like to make one comment. I don't know who is on your panel or advisers that you have now, but I would appeal that this calls for a partnership of not just media people. There are a lot of media geniuses, and a lot of really sharp people on Madison Avenue who can sell a new serial

or a new soap or a new car or convince us to buy a Japanese car or whatever. What we are talking about here is a need to combine, perhaps for the first time on such a serious problem, the scientific and technical knowledge that is coming out of the research community, coming out of our educational system with those people who know how to get the message out, That kind of partnership has to be an ongoing partnership. The third component which I think is sort of new is the tie-in to that community-based organizational network that exists in this country, serving many different kinds of people with different ethnicities, with all different kinds of problems. It is a very complex thing, and it is very easy to just say, "We are going to turn it over to Agency X, and we will put an advisory group over them, and that way we will track to make sure the right messages are going out." It calls for a very localized approach, I think even in the media arena. As a minimum to have regional operations, to have regional agencies. I think to have minority-owned agencies who have a different way, whose specialty is dealing with minority communities and not necessarily believe that a J. Walter Thompson or Mozelle Jacobs or what have you can coordinate and tackle this job. It is more of a regional problem than it is a national problem.

MS. VAN NESS: We couldn't agree more, and we are working as best we can with community-based organizations, with minority-owned advertising agencies, with people from the sciences, from academic institutions and across the board. That while we have made some progress there is much more yet to be done and many more people. An opportunity like today brings other people to the attention that we can begin to draw on.

MR. OAXACA: We are out there on the other side of the Mississippi.

MS. VAN NESS: That is where I come from. So, I know.

CHAIRMAN WATKINS: Yes, Ms. Gebbie?

MS. GEBBIE: We have asked other times for examples that might be provided, not here at the table but at a later time, but I would be particularly interested if any of you know of a health-related campaign where we have melded some kind of national slogan or image with local events. I was intrigued with the idea of the cutout in the drug store that matches the logo you saw on TV, and I am certainly aware of that in other areas, but I have limited awareness of successful examples of doing that in health-related arenas. And any sample materials or descriptions of such campaigns in any health-related area that you could bring in that could be illustrative of what you think could be helpful around HIV, I would, like to see, and I think it would be helpful to the panel.

MR. OAXACA: Remember the March of Dimes in polio, Franklin Delano Roosevelt? I am dating myself, but there was a national campaign that I remember as a kid seeing the little crippled kids giving your dime. You would see them in drug stores, grocery stores, and it worked. I think we beat polio.

MS. GEBBIE: As you say that, I can think of several rooted in voluntary associations that pulled that together from their own -- I think of the Heart Association, but not ones that mixed government and the private sector across the lines that I think you have been talking about here. So, I would urge you to look around a little bit, and if you can send something in that regard, it would be helpful.

CHAIRMAN WATKINS: Let me follow up on that and maybe try to put it in this kind of perspective. Supposing that the Congress of the United States, instead of ordering a mailing campaign, had brought you three together and said, "Look, we want to put this kind of money against a media campaign in the United States that will reach the most people, be the most sensitive to the cultural differences, be sensitive to those both in and out of the mainstream." Can you bring together the best minds you have across the board from the media, the scientific community, all aspects and you design that system? Some may well be a national mailer. Some may be sufficient information for regional mailers. Some may be the kind of thing you want to put into regional electronic media. Some you may want to put into regional or local cassettes with some kind of written document. Some you may want to have in a variety of languages in a variety of formats within that language that would reach the people. Would you have come up with the CDC mailer program that you now have?

Dr. Nickens, what I am saying is we have an opportunity here. You know, the Congress is looking for answers, too, and I am not down on them. They are frustrated, and so, there is a feeling that somehow a mailer is going to do the job. You are telling us at the table today that the mailer may have limited value, and even the CDC people who come before us have kind of winced when we talk about the mailer almost as though it is directed upon them, and it was, in a sense, but supposing we had gone back to Congress with an alternative. We have 42 organizations we want to bring together in a conference with workshops and design an educational process that is perhaps unique and goes back to Mr. Oaxaca's concept of what went on with the March of Dimes in the thirties. I guess what I am saying is can't we design the proper program and make a recommendation on how we might do such a program properly along the lines where we have plenty of flexibility, plenty of local involvement where that seems most appropriate and provide the kind of funding streams that would go in different directions that CDC could well control under some kind of an advisory body with the Oaxaca's and

Hayes-Cozier's sitting right there helping you out? Certainly we have sensed this in the Commission so far, and we have had close liaison with a range of ethnic cultural leaders who can give us some advice. Jane Delgado has been one of our great advisers in the Hispanic area so that we don't do the wrong things, and we don't show a lack of sensitivity. We have wonderful Dr. Primm on our Commission and many other members of the black community on our staff who do have that sensitivity and have worked on the Hill in health and education matters for minorities, and so, they are very sensitive. So, we need to have that kind of a strategy, it seems to me, and this is something that we could recommend in our report on the media. Now, we are going to have more media discussions even this afternoon, as you know. So, we are not there yet, but you are leading us up to that, and perhaps we could ask your colleague, Paula Van Ness and you, Dr. Nickens, maybe to have an executive session with Mr. Oaxaca and Ms. Hayes-Cozier and sit down and talk about it a little bit and then let us chat about it to see if out of this we can divine a concept which might make more sense and not misuse resources that are already scarce. The best minds here might say that this isn't the best way to get the maximum bang for the buck, and let us go for a different approach that has more flexibility, more local flavor, more regional flavor, less national direction.

DR. NICKENS: I would be pleased to do that.

CHAIRMAN WATKINS: Would you be willing to join in with that effort? I am not looking for the absolute final but just conceptual approach that you might take and the kinds of people that should be brought together in the planning phase very early in such a thing. I think the jury is still out on educating the American people. We have not homed in on it until today. It is beginning to come alive, in your discussions, and perhaps how we are jousting with windmills on these mailers. We already went out with one mailer to the public health people and others. I forget how many went out, 15 million, I believe. I think that is a gimmick more than a substantive well-thought-through strategy, even though the intention is right.

MR. OAXACA: Another reality that I faced personally before I started doing volunteer work in Los Angeles, I wasn't sure I wanted to be associated with the subject. People would say, "Has Oaxaca got AIDS or gee I didn't know he was that kind of guy," etc., you know, and then you begin to develop some confidence because you talk to other people who are not afflicted with a problem and who are willing to play in the game. I have talked to corporations in Southern California. I have talked to a few friends I have at the national level. They don't want anything to do with the subject. They are in consumer products. They are doing something nice and clean and pretty, and it is on television on the Cosby Show or whatever.

They don't want to deal with this very nasty subject. They think that is going to turn off their consumers, and so we have still got some bridges to cross in getting a lot of the normal leadership that you might have on something. At least with polio there is life, there is hope. Here there is no hope perhaps once the disease is there, and so, we have got to get prominent people in this country, the politicians, the business community, the US Chamber of Commerce, the National Association of Manufacturers, those people who spend money on a lot of causes who are willing to participate. We have got to bring them on board that this is their problem, as well. Once you cross that bridge, once you begin to make some progress there, then I think that the kinds of things that we have been talking about can begin to work. A mailer is just one possible tool, but you have got to turn on some big machines to deal with this issue, and frankly, I know what I do with my mailers.

CHAIRMAN WATKINS: I tend to agree, Mr. Oaxaca, but we have to acknowledge some incredibly important business leaders in the nation who do have the message. I have been in conferences with them. You have many in California and large organizations that have really very progressive thinking on AIDS in the workplace and what they have done to prepare the way for a sensitive and compassionate treatment of their employees, When it happens, they ride right through it beautifully, and those are well documented. We just had an All-State sponsored forum back here where you had CEO's from all over the country, very concerned about this and trying to get in the act. I agree, it must go further, and they have a large role to play, but they, too, as many of us who were ignorant of the scope and depth and breadth of this disease, they are coming aboard. So, I think now is the time to inspire that even further, and I think we can do that with this kind of approach. I could give you the names of five or six CEO's who could participate in a collaborative planning effort to do a better job in reaching out to all aspects of America, not just into the schools but out of the schools, not just into the workplace but out of the workplace, and I think that is the kind of strategy that would be -- that conceptual strategy might be very valuable. Perhaps even with congressional participation with very interested people to take the message back to the Congress to allow the pros to build the media campaign, give us the incentive to do it, but let us work together on it to build the very best one we can because we don't have a lot of time.

We heard the stories today about adolescents, both the drug use and sexual activity, sexually-transmitted disease problems and certainly the kernel of everything you need for HIV in adolescence. So, those are the kinds of things we have to do better right now at in getting the message out, and we don't have a lot of time to waste another year to find out the mailer only had 4 percent effectiveness in the nation. That is not a good

statistic to get. We should do better front-end planning and then expect 85 percent effectiveness or something like that.

DR. NICKENS: I would like to make one comment. When we talk about media and advertising, I am a little uncomfortable. I think that we have said it, but I would like to reinforce again that what we are talking about with AIDS is not the sort of passive message reception that is involved in deciding to buy Cheerios instead of Wheaties. This is really profound behavior change we are "marketing," and around behaviors that people have investments in and about which they are very sensitive. I think that in that sense with minorities, what we need is full partnerships, and we cannot have minorities as passive recipients of something that is created. The partnership issue is a critical one to make this really fly.

CHAIRMAN WATKINS: If we can get a hardened up version of what this discussion is from you all, it may give us some insights on a recommendation the Commissioners would feel comfortable with and where we could make a major impact on how we would keep the information flow going. It is not just media, and I agree with that. It is information flow in a variety of modems, and certainly the media is a very important one.

Are there any other follow-on questions before we shift to the next panel? Anyone? All right, thank you very much for coming before us today. I think you have given us a real help in one important area that we need to address in our report.

Our next panel is a large one on education efforts of community based AIDS organizations. Mr. Gil Gerald, National AIDS Network; Charles McKinney, Director of Education, Gay Men's Health Crisis, New York; Tim Offutt, Executive Director, Kupona Network, Chicago; Dominick Maldonado, President, Hispanics United Against AIDS, New Haven; Jack Stein, Executive Director, HERO, Baltimore; Mr. Shepherd Smith, Jr., President, Americans for a Sound AIDS Policy, Washington, DC; Dr. John Holloman, Chairman, AIDS Task Force, National Association of Community Health Centers.

I want to welcome you all to the panel. In this panel I know we have members who have worked very closely with one of our Commissioners over the last several years, Beny Primm, and he asked me to please apologize for him for racing out on you. He really didn't mean to do that, but he has other commitments to the President's Council on Drug-Free America. So, he would fully have expected to be here. So, Mr. Gil Gerald, Mr. Tom Offutt and Dr. John Holloman, if you will forgive Beny, then we can start the hearing today. Thanks very much for being here. You get him after the hearing.

Our first statement then today, and because there is a large panel, if you go much over 5 minutes, you are going to see me kind of raising up my hand. Try then to wrap up your comments because we are all caught up in this, and I know that each of you want to give us your best shot, but I hope it is in writing to us. We do read those very carefully, and we get a great deal out of the dialogue. Sometimes we flush out something that isn't even in the first written statement. It is not in a follow-up oral discussion, but it comes out of the back and forth, and I think that is where we have made the most money so far. So, if we could start then with Mr. Gerald?

MR. GERALD: Admiral Watkins, distinguished members of the Commission, rather than read from my full prepared text which has been submitted to you, I will use the brief time allotted to me to summarize and highlight major points of my report.

I would like to begin by stating that compared to the need, there are only a handful of model programs for educating communities and there remain huge portions of the population that have only been given the most rudimentary AIDS information. We must learn from the successes of these few model programs.

Certain challenges relating to AIDS education efforts are true, regardless of the target population. The term "education" encompasses efforts to affect the knowledge, attitudes and behaviors of individuals relating to both their risk behavior and their general understanding of AIDS and HIV infection. Knowledge does not necessarily mean that an individual has the attitudes or skills to change particular behaviors, as we have seen demonstrated in the case of education around the risk of cigarette smoking. We have, also, come to recognize that for education efforts to be effective, they must be specifically targeted, taking into account differences in culture, language, life styles, educational levels and possible risk behaviors. The need for targeted education, the array of educational vehicles and messages, and the controversial nature of some of the messages, all highlight the crucial role of community-based education.

The primary challenge of educational efforts is no longer one of imparting basic facts about AIDS transmission. Over 90 percent of Americans now know that AIDS is spread through sexual contact. Broad media coverage over the past 3 years is largely responsible for the successful widespread general knowledge about AIDS.

Successes in altering attitudes and behaviors have unfortunately been far less common. Successes in efforts to change behaviors can be found in community-based efforts targeted at gay men, particularly white gay men. The January 29, weekly morbidity and mortality report of the Centers for

Disease Control contrast rates of infectious syphilis among heterosexuals and homosexuals in 14 localities across the country. Changes in these rates are markers for behavioral change. Male heterosexuals recorded better than a 75 percent increase, while homosexual and bisexual men report a 34 percent decrease.

Education efforts in some major metropolitan areas have lowered the incidence of HIV infection to 1 to 4 percent among gay and bisexual men. Unfortunately, however, the successes, also, show how far we need to go in this area. Significant populations of individuals at high risk are hardly being addressed or not being addressed at all. These populations include those in rural areas, the chemically dependent, black and Latino gay and bisexual men, individuals with low education, homosexual and bisexual adolescents and bisexuals and minority women.

In addition, the problem of recidivism is very real. Education is, also, crucial to efforts to curb the epidemic of fear and anxiety. Community-based educational efforts are best positioned to bring home the message that AIDS is an issue that all communities must address, hopefully with compassion. How people with AIDS will be treated by their community is closely tied to the nature and content of AIDS education activities.

Mr. Chairman, there is no one right way to provide AIDS education. Approaches must be varied and targeted to the specific populations being addressed. Reinforcement of educational messages is essential to ensure maintenance of any behavior change. AIDS is a health concern that places stresses on many parts of our society. Education both through the message and through how communities come together to develop the message, provides a crucial vehicle for bringing home the fact that this disease is indeed everyone's concern.

Funding for education efforts must be increased substantially across the board, particularly federal funds for community-based education. Funds should be distributed directly to community-based agencies. State health departments, if they are receiving funds for community-based efforts should receive funding only upon proof of working in cooperation and with the involvement of community-based agencies in their state.

The distribution of resources and funding of community-based agencies should, also, reflect a high incidence of AIDS within certain communities and among certain population groups as well as an assessment about communities at higher risk.

Now, what I mean by this last statement, for example, there are communities with low HIV seroprevalence among IV drug users. We have parts of the country, the West for example,

where you have high incidences of IV drug use but low seroprevalence rates among this group. That is a place where we need to put some investment in prevention. Thank you, sir.

CHAIRMAN WATKINS: Thank you, Mr. Gerald.

Dr. McKinney?

DR. MCKINNEY: Mr. Chairman, members of the Commission, my name is Charles McKinney. I am Director of Education for the Gay Men's Health Crisis in New York. Thank you for your interest in my testimony regarding the educational efforts in community-based organizations in the fight against AIDS.

Gay Men's Health Crisis, Incorporated, is a community-based organization serving the five boroughs of New York City. It is one of over 300 community-based organizations that the National AIDS Network (NAN) which provide support services and education in local communities across the nation.

Gay Men's Health Crisis, (GMHC), incorporated in 1982, represents the first organized effort of a community to defend itself, in the absence of public health leadership, against the dread disease, AIDS. In the past six years it has provided direct social support to over 6000 people with AIDS, and it has altered the course of the epidemic in New York City through its educational initiatives to halt the sexual transmission of the HI virus among gay and bisexual men.

AIDS is preventable. This has been demonstrated clearly in the gay community. Surveillance statistics from both coasts document reduction in the incidence of sexually-transmitted diseases and the rate of HIV seroconversion within the targeted populations of AIDS prevention programs. Simultaneous increases in the incidence of sexually-transmitted disease and the rate of HIV seroconversion have occurred within the populations that were not beneficiaries of aggressive risk reduction programs.

Empirical evidence has been established as well, by GMHC and others, to confirm the effectiveness of education as an AIDS prevention strategy among gay and bisexual men. The validity of inferring generalizations from these findings that extend to other populations, or to the public at large, is not known.

In the absence of a vaccine, and in the presence of the only measurable success in controlling the epidemic, education is perceived to be the most positive public response that is available in the face of an epidemic that progresses exponentially without marked deterrent. The inherent danger in

this logic is to embody education with curative power outside the context in which it has been found to be effective in reducing the risk of HIV infection in the gay community.

Education as a life-saving strategy in the fight against AIDS is more than a public service announcement recommending sexual abstinence, saying, "No," to drugs or using condoms. It is multifaceted, omnidirectional, persistent, repetitious and immediate. It is round the clock, in the streets, in recreational facilities, churches and synagogues, social clubs, homes, schools and local super markets. It is where the people are, whenever they are there. It is communicating in a common language and level of literacy. It is non-judgmental. It is sensitive to cultural differences, patterns of speech, rituals and mores of diverse populations that make up the community. It is "hands on." It is "no holds barred". It is "grassroots". Success in the gay community has not been achieved from a distance.

This is the AIDS prevention education that has worked. It is beyond the scope of the established Public Health Service to deliver. It is a model the community-based organizations have developed over the past six years of fighting to contain the virus.

By the fault of the Federal Government, community-based organizations have been the vanguards in the fight against AIDS in the United States. They have mobilized a volunteer army of seasoned veterans attached to the 300 community-based organizations of the National AIDS Network.

Gay Men's Health Crisis brings to that network a force of over 2000 committed volunteers who provide direct services to New Yorkers with AIDS and who provide educational and informational support to 14 million other Americans who live and work in and around the city of New York.

The American people are eager for information and leadership. This is illustrated profoundly in the demands for services directed to Gay Men's Health Crisis by our non-gay community. Despite a selection of AIDS hotlines available to New Yorkers, the GMHC hotline is providing reassurance, education, and referral services to nearly 7000 callers each month. A large and increasing percentage of our calls are from women and others of the non-gay community, who perceive GMHC as the most creditable source of AIDS-related information.

Concurrent with our hotline activity, our peer counselors are staffing information tables in the streets, as many as 70 a month, at neighborhood and ethnic events, church functions, health fairs, the post offices, the parks, the piers

and other high traffic areas where New Yorkers congregate for business, education, and social and recreational activities.

Off the streets we are conducting risk-reduction programs in a Wall Street sauna, a social club in Harlem, and for the theater and dance companies of Broadway shows between the matinee and Wednesday evening performances. We are consulting for the American Management Association on "AIDS in the Workplace", and on an AIDS curriculum for teenagers with the New York City Board of Education, and a nationally distributed Scholastic Magazine. We are training counselors for the Coalition for the Homeless and for Covenant House, so that they can discuss AIDS risk reduction with their counselees. And we are providing AIDS educational literature to the Police Academy, 16 correctional facilities and the 202 public libraries of the New York Public Library Systems.

Our staff and volunteers are conducting educational interventions to prisoners on Riker's Island, and to recovering intravenous drug abusers in resident treatment programs. We are presenting to the Board of Directors of the Metropolitan Opera Company and are providing the only AIDS education and training available to the professional staffs of 280 community-based mental health agencies serving the five boroughs of New York City. We are presenting to the Narcotics Squad of the New York Police Department and to the Criminal and Civil Court Justices of New York State on the psychosocial aspects of AIDS, and we are reviewing the medical literature and distributing relevant updates on treatment therapies to 300 physicians in New York who are providing medical care to New Yorkers with AIDS.

It is this grassroots effort that holds the greatest potential for success in controlling transmission of the HI virus and containing the AIDS epidemic. The crisis of confidence that exists between a people that has witnessed the ravages of AIDS and a government that continues to debate its epidemic potential in the fact of 50,000 casualties will not be eliminated by the most imaginative bureaucratic response.

Effective intervention to contain the virus will combine the resources of government with the experience, expertise and manpower of its grassroots constituency. We ask that the Federal Government support the initiatives of community-based organizations by providing the necessary resources to maintain and expand their efforts in behavioral research and risk reduction education.

The Federal Government by its non-participatory stance in the fight against AIDS, has created the major obstacle impeding the educational efforts of community-based organizations across America. Characteristic of its posture is the political pandering to special interests that are taking

advantage of the health crisis to disadvantage those stricken by the disease and to condemn and penalize organizations that have achieved the only success in containing the epidemic.

We implore our government to follow the recommendations of the Surgeon General of the United States and the most learned of our statesmen from the scientific community and the Public Health Service in defining AIDS as a public health issue and the HI virus as a public health emergency. Before and since its incorporation in 1982, Gay Men's Health Crisis has advocated for national leadership in the fight against AIDS. We have testified before Congress and committees of the Congress to heighten awareness of the impending crisis, to increase funding for medical research, and to urge the Congress to accept a leadership role in the national emergency presented by AIDS. The response of government has been meager. In the absence of national leadership, that role has been imposed on GMHC and other respected organizations of the National AIDS Network. We have shared our experience with community organizations throughout the United States and have shared our expertise with public health officers representing more than a dozen countries of the Western World.

This is a role that has been thrust upon us, and it is one that is the responsibility of national leadership. We ask that the President and the Congress of the United States accept the responsibilities for leadership in the fight against AIDS in America, and aggressively confront the national emergency that AIDS presents.

Mr. Chairman, members of the Commission, this concludes my testimony.

CHAIRMAN WATKINS: Mr. Offutt?

MR. OFFUTT: Thank you, Mr. Chairman. Mr. Chairman, members of the Commission, on behalf of the Board of Directors of the Kupona Network, I would like to thank you for this opportunity to testify before you today on the issue of AIDS education, specifically within the black community.

Mr. Chairman, the Kupona Network came into existence back in October 1985, out of a concern over the lack of educational activities aimed at the black community about the AIDS epidemic. Because of the lack of racial and cultural sensitivity on the part of many of the predominantly gay white male AIDS organizations working on this issue for the past 5 years, most efforts to educate the public about AIDS and risk reduction have not had a significant impact on the black community. Many in the Black community still believe that AIDS is a gay white male disease which they are immune to, if they stay within their own community. Others see it as a judgment

against those who have engaged in, quotes, "sinful" or, quotes, "immoral behavior". Some see the epidemic as a conspiracy against the black community by those who harbor racist attitudes towards it, and still others see it as yet another burden that has been placed upon the backs of black people who are already overburdened by unemployment, poor housing, lack of educational opportunities and substandard health care. Many feel that blacks are being blamed for the origins of this epidemic. These perceptions are real, and they are barriers to effectively educating the black community and changing risky behavior.

Mr. Chairman, until recently, it has been extremely difficult to interest national black organizations, such as the National Urban League and the Southern Christian Leadership Conference or for that matter their local affiliates in the impact that the AIDS epidemic was having on black people. Like so many in the black community, these organizations found it convenient and expedient to ignore the problem in hopes that it would go away. It is essential that organizations involved in educating the black community about AIDS be prepared and capable to carry out this task. What I mean here is that community-based organizations wishing to do AIDS education must be able to relate to all segments of the black community, including those members who identify themselves as being homosexual, bisexual, as well as those persons who do not identify with their sexual behavior.

The black community must be given permission by those who seek to educate her to openly discuss some deeply personal and very sensitive issues related to patterns of sexual behavior which directly affect HIV transmission. Clearly such permission can only come from within the community itself. When the Kupona Network first started our educational efforts, we knew that it was of vital importance that the black community see other black people giving out this information and being concerned about this issue. We were acutely aware of past attempts at educating the black community about AIDS which were undertaken by AIDS organizations outside of it. These efforts, for the most part were inept, superficial and insensitive to black people and their perceptions about this disease.

Mr. Chairman, I am happy to state that the efforts made by the Kupona Network with the support of the city of Chicago Department of Health and the Illinois Department of Public Health are beginning to have an impact on the black community of Chicago. While we recognize the fact that our efforts have been small in comparison to the size of Chicago's black population, I feel that we have begun to have an impact on some important and influential sectors of our population, and this would include the educational system in the city of Chicago, as well as the Illinois Department of Children and

Family Services which provides care to many black and Hispanic children in the city of Chicago.

I, also, wanted to add that Kupona Network recently was able to do an hour-long program on AIDS in the black community on the No. 1 radio station and the city of Chicago. They were willing to preempt some prime time driving hours to air this program, and we were flooded with calls as a result of this. I believe our listening audience at that time was about 600,000 listeners.

Mr. Chairman, I would be remiss if I did not comment on the historic role that the black church has played within the black community. The Kupona Network has maintained all along that the black church must be involved in educating the black community about AIDS and to this end a few months ago we saw the establishment of the Chicago Black Ministerial Task Force on AIDS which currently numbers about 35 clergypersons from a variety of denominations who are actively involved in both recruiting other clergy members to be involved in this effort and, also, providing services within their own churches.

The Chicago Department of Health under the leadership of Commissioner Lonnie Edwards has been a strong supporter of our efforts and the efforts of other minority grassroots organizations who are working on this issue. They have been invaluable in assisting us, both in terms of identifying resources to be used in our educational programs and in recognizing the necessity for a community-based response to this epidemic.

In summation, Mr. Chairman, I would like to put forth four recommendations; No. 1, that the Federal Government needs to increase its level of attention and involvement concerning the issue of AIDS in the black community; No. 2, that the Federal Government needs to follow the example of our European counterparts in developing a comprehensive federal approach to addressing the AIDS epidemic, an approach which does not merely look at issues of seroprevalence; No. 3, that the Federal Government should make every effort to support the development of a community-based response to the AIDS epidemic, particularly in minority communities and, also, that the Congress and the White House increase the level of funding to the Office of Minority Health and that OMH be empowered to make grants directly to community-based organizations. Thank you

CHAIRMAN WATKINS: Thank you very much, Mr. Offutt.

Mr. Maldonado?

MR. MALDONADO: Good afternoon, Admiral Watkins and members of the Commission. Before I begin my presentation and

about Hispanics, I feel there is something I must share with you that is not part of my presentation as it may have an impact on it.

Last Monday, the twenty-second, I accompanied one of my best friends, a member of this organization to the doctor. The same day he was hospitalized. On Tuesday he was diagnosed as having full-blown AIDS, and on this past Monday he passed away. I planned to cancel my presentation. However, during my 7 days at his bedside, he asked me to come here to make the presentation, and that is the reason that I am here now. I ask you to please bear with me as I read the statement.

I would like to begin by thanking you for the recognition you have given to Hispanos Unidos Contra SIDSA/AIDS by inviting me here to speak with you. I hope my comments will be helpful, as you try to determine the ways in which the Federal Government can best promote community-based AIDS education programs. It is difficult, perhaps, for people whose first language is English and native culture is US to appreciate the barriers Hispanics encounter every day in this country. I come from New Haven, Connecticut, where there are roughly 12,000 Hispanics in a city of 130,000. Most of us are of Puerto Rican origin, and half of us have income levels below the poverty line. Hispanic women in New Haven suffer a higher rate of infant mortality than any other group because seeking prenatal care is not common to our culture. When you introduce the AIDS virus into this situation of poverty, language barriers and cultural obstacles to care for, you have trouble. Currently 17 percent of all the Hispanics with AIDS in New Haven are Hispanic, and the percentage keeps growing. Up until last June when the Coordinator of the Mayor's Task Force and I did the ground-breaking work to organize Hispanic Unidos Contra SIDA/AIDS, there wasn't a single Hispanic organization in the state devoting a large part of its energy to educating Hispanics about AIDS. Although we had a hard-working AIDS project in the city, they didn't have Hispanic educators, but even if they did have Hispanics, the prevailing lecture format would have not been effective. In addition, all of the available AIDS materials in Spanish distributed by the State Health Department were translations from a complex and visually unappealing text.

All of these facts added up to one thing. We needed to get together and do it ourselves. We needed community people with energy, ideas and commitment to develop our materials and to get out the message about AIDS in a culturally sensitive way. So, we got together. Before I tell you about what we have done and what we are doing, I want to tell you about who we are as individuals and as a group. I believe this information is very important because we understand it as the key to our success so far. When Sher Horosko and I organized the group in the beginning, we were very careful to choose community people and I

emphasize community. This does not mean that we went to the heads of all the Hispanic agencies, the pastors of all Hispanic churches and the PHD's in the academic community. It means we sought out people who had their fingers on the pulse of the community in all its variety. These people included individuals who work with IV drug users; people who work in the prison system as ministers or probation officers; individuals who work with Hispanic teens; individuals who work in clinics serving Hispanics; pastoral workers; social workers and teachers. These people are not afraid to roll up their sleeves and do whatever needs to be done.

We have found it very important to the group's empowerment to identify and acknowledge the unique contribution each individual makes to Hispanos Unidos Contra SIDA/AIDS. For instance, two women members of our board are active in the Pentecostal Church which is a significant source of authority in our community. It is clear that these two women are precious links to a religious community we must talk openly with if we are to get anywhere with our AIDS education efforts.

Other members of our group have experience with IV addicts. These people help establish connections with the drug users who designed the brochure to reach out-of-treatment addicts. In Hispanos Unidos Contra SIDA/AIDS, we have tried to tap the connections and experience each of us brings to our collective effort.

I would like to share some highlights of our work with you, and as I do, I would like to ask you to keep in mind that we did all this with absolutely no money. To begin with, before we did anything, we decided to draft a plan. Having our direction clarified early on has helped us to stay in focus. We visited all the Hispanic services agencies in the city to give them basic information about AIDS. We gave two training sessions to members of Hispanos Unidos Contra SIDA/AIDS in the Hispanic Community. At these sessions we show a video that gives basic information about AIDS and we do role playing involving the whole group so they can get practice in responding to various situations. In one role play we acted out a church meeting in which there was a strong disagreement as to whether a person with AIDS should be allowed to remain in the congregation. We set up AIDS information tables at Hispanic Summer Festivals and walked through the crowd with AIDS information.

In view of the lack of materials, Hispanos Unidos developed two brochures in Spanish, one designed to reach IV drug users with information about clean needles and condoms, the other designed to reach the general public. All of the materials were pre-tested on at least 20 people from the Hispanic community, and you will find these materials in your packet. You will, also,

find two brochures in English which I am happy to say are translated from the Spanish rather than the other way around.

At the end of October for AIDS Prevention Month, we held a March for Life against AIDS that over 150 people attended. Following the march, we went out into the neighborhood, going from door to door with AIDS information. People were more than willing to talk with us. Although our main focus so far has been educating our own people about AIDS, we have felt an intensifying need to involve ourselves in issues of care for Hispanics with AIDS.

We have just completed three sessions on psychosocial and cultural aspects of care for Hispanics people with AIDS that was given by a Hispanic psychologist with expertise, both in AIDS and in counseling Hispanics. Our plan is to train a corps of volunteers who will be companions to the people with AIDS in our community. We, also, intend to begin a support group for Spanish-speaking people with AIDS, ARC or HIV seropositivity within the next few weeks.

As the months go on and each of us finds that we know someone with AIDS, the issue of culturally sensitive care for our people becomes more crucial. We have done all this with total volunteer energy. Right now we are trying to raise the funds we need to get a little store front going, and we are trying to hire an executive director who can save our energy. I hope you are wondering why we haven't got any money from the State Department of Health. Despite the fact that the legislature allocated $2.7 million to do AIDS work, not one penny has come to Hispanos Unidos Contra SIDA/AIDS. The State Health Commissioner hired a minority consulting firm from Silver Spring, Maryland to do community-based education with blacks and Hispanics in three Connecticut cities. They spent the first 5-1/2 months and $365,000 on developing their plan. The majority of that money went to Maryland to fight AIDS in Connecticut. The Mayor's Task Force on AIDS has written three grants for us, just so we could get going. The band is playing on and on in Connecticut while people are dying.

What can the Federal Government do to fight AIDS that will really make a difference? It can fund community-based organizations with energy and commitment. Organizations have the trust of the people and the respect of the community. This will get you the most for your dollar because whatever comes from the people is what the people need. It seems to me that the United States Conference of Mayors has done well in funding programs that are both innovative and community based.

All we need is continued funding for these programs, and we will be doing well. In terms of reaching the minority communities, in particular, the Federal Government can encourage

strong working ties between local AIDS groups that are often white and middle class and minority agencies. There could be more collaborative efforts that stress the role AIDS groups can play in helping minority organizations develop their own AIDS action plans. Hispanos Unidos Contra SIDA/AIDS and the Mayor's Task Force on AIDS work very closely together, and this has been a source of strength to us both.

Finally, the Federal Government can help community-based organizations survive the big state politics of AIDS. You can fund us when our State Health Department won't. You can help us with technical assistance. You can give us some of the tools we need to fight AIDS in our community. Thank you very much.

CHAIRMAN WATKINS: Thank you very much, Mr. Maldonado, and we very much admire your willingness to come forth today and bring that important message. It rings well with the sensitivity that the Commission has, and we have listened very loud and clear to those most affected by the virus, and so, we thank you for bringing that message to us today. We need to remind ourselves as we discuss bureaucratic issues that we don't forget the human beings at the end of the line here which should be our principle and continuing focus. So, we thank you for bringing that to us today. Mr. Stein?

MR. STEIN: Thank you. Admiral Watkins, Commissioners, I would like to extend my appreciation for inviting me here today, and I could not leave without, also, recognizing the Commission's activities over the last several weeks in terms of effecting some change because change is what this entire epidemic and stopping it is all about. I will keep my remarks as brief as I can. I would like to address three major areas, No. 1 how I see the role of a community-based organization with respect to AIDS educational efforts; two, to take a brief look at some of the impediments that have gotten in our way to do some of the work that we would like to do and feel we need to do more, and thirdly, some recommendations for some further action.

Briefly about my organization, it is entitled Health Education Resource Organization and commonly goes by the term HERO. It is a Baltimore-based AIDS service organization, however. HERO provides services for the Metropolitan Baltimore area, as well as in Montgomery County which is the county between DC and Baltimore and, also, the western part of Maryland.

We have been in existence for the past several years; 1983 is when we began, and we currently provide a variety of services including targeted outreach education to at-risk populations, general community information and referral, health

care provider education and direct patient support and assistance. We are, also, responsible for the development of a variety of educational materials that are distributed nationwide and throughout the world, and you have some samples of that as well. Many of the remarks that I was planning to say have already been addressed, and so, I will try to keep my remarks succinct.

With respect to the role of the community-based organization in HIV prevention and education, I think I could summarize them into nine major points. First of all, AIDS service organizations like HERO have really been the first responders in this epidemic. By that alone, I think we often view ourselves, rightly so, as the experts in terms of our on-the-job experience over these last years. So, perhaps what we did not have from our educational backgrounds we learned literally by doing. Second, AIDS service organizations are composed of individuals who are working with and by people most affected by the epidemic. Clearly the commitment is there in terms of our desire to do this type of work. Third, the use of volunteers is critical. There cannot possibly be enough funding and resources to accomplish what we need to accomplish without the benevolence of the community. We currently have a volunteer pool of over 400 individuals of very diverse nature.

Fourth, AIDS service organizations like HERO have begun to recognize the need to expand their initial target populations. We tend to view AIDS as a moving target which means we need to expand the populations that we work with.

Fifth, AIDS service organizations are in key positions to provide targeted educational programs that require culturally sensitive and sometimes controversially viewed messages related to life style activities. Often these understandably cannot be conducted by a health department.

Sixth, AIDS service organizations are important clearinghouses for collecting and disseminating information related to HIV-related issues affecting communities. HERO, for example, operates for the State Department of Health and Mental Hygiene in Maryland the Maryland AIDS Information and Referral Hotline.

Seven, AIDS service organizations are in excellent positions to assume responsibility for outreach programs that impact on the diversity of service providers. For example, we currently operate a street IV drug outreach program where we have hired former drug abusers who are currently trained and educated and supervised by our staff and are out there in the streets on a daily basis doing outreach on street corners.

Eight, AIDS service organizations have been very effective in encouraging coalition building within the community in working with existing service providers, and lastly, AIDS service organizations are excellent points for directed fund raising efforts to increase the public, as well as the private sector funding devoted towards HIV prevention education.

In terms of the barriers, unfortunately there have been many of them. I am sure you have heard a lot of them at this point. For us we have experienced, no doubt, one, widespread public denial, that is a given; two, initially some strong resistance by health departments and other governmental agencies; third, certainly inadequate funding. We always hear about inadequate funding. Ironically, however, as funding began to increase and programs such as my organization began to be funded, lots of money was in a sense dumped into our laps without a clear understanding of how it was going to be monitored, without, also, a lot of good administrative support to keep it fiscally accountable which in a sense sometimes sets us up.

Fourth, a lack of a state plan, and until most recently, and I need to give credit to our State Department of Health and Mental Hygiene -- until most recently there really wasn't a state plan in which we could help design our own plans for future needs.

Fifth, limited available research data on the effectiveness of prevention and education strategies have made it very difficult for us to design a program when, in fact, we are really going by the gut.

Sixth, inadequate funding for evaluation of programs. Many of the programs that we have operated these last 5 years, we can only say that we think they are working as opposed to we can say that we know they are working because we really have not had strong evaluation components built into them due to funding issues.

And lastly, AIDS service organizations' roles have become challenged over these last several months, last several years for a number of reasons. AIDS is now becoming a very popular issue for groups to become involved with. There are consulting agencies all over our state, all over our country who are now beginning to go where the money is, and in fact, we are being challenged because of their expertise and their ability to respond to requests for proposals. Even from the federal level we are, in a sense not able to respond to several federal types of grant money because of specific requirements as an existing agency that we do not hold.

My recommendations are rather brief. I would certainly recommend highly a comprehensive national strategic plan to prevent HIV transmission in order to involve the local level. This plan, no doubt, needs to acquire the acknowledgement that HIV prevention education is based on permanent change of the most fundamental and intimate human behaviors. These are not one-shot deals. We are talking about changes on an individual level, professional level, as well as on a societal level. Second, I would certainly recommend that all requests for federal funding to conduct prevention education should include the provision for active participation of the AIDS service organizations in them, build it right into the proposal process.

Third, states must be encouraged to include representatives from AIDS service organizations not only in the product they create but in the actual process of putting it together, the planning process. Fourth, we need technical assistance. AIDS service organizations need this in order to enhance their ability to appropriately respond to the increased demands placed on the community by HIV. This technical assistance may take many forms. It may take the form of management. It may take the form of fiscal accountability and reportability. It may take the form of technical assistance in terms of research.

The last two points are sixth, the establishment of community-wide coalitions are critical and need to be encouraged, and lastly, with respect to development of prevention education material, AIDS service organizations no doubt need to be accountable but accountable on a local level rather than on a federal level in order to simply adapt to what the atmosphere is in the local community. I thank you for my comments.

CHAIRMAN WATKINS: Thank you very much.

Mr. Smith?

MR. SMITH: Mr. Chairman and members of the President's Commission on HIV, thank you for the opportunity to testify on behalf of Americans for a Sound AIDS Policy, an organization actively involved in educating the general public, health care workers, businesses and minority segments at the present time.

In the interests of time, I will not present my entire prepared remarks. With me today is Michelle Fieldsharl our minority projects coordinator, Anita Mooreland Smith, our vice president for communications and Jeff Collins, director of Love and Action, the national AIDS organization we support which gives comfort to people who are infected with the human immunodeficiency virus.

DR. LEE: Could they stand up, so that we can see them?

MR. SMITH: Surely. The focus of these hearings is prevention and education, and one cannot imagine our stopping the spread of this epidemic lacking the discovery of a cure or vaccine without each of these important elements. At present approximately 1/2 of 1 percent of the American public is infected with the HIV, leaving 99-1/2 percent uninfected. It is our obligation to see that the uninfected portion of the population does not become infected while dealing compassionately with those who are unfortunately HIV positive.

As a citizen's organization dealing with AIDS, we represent largely the uninfected public. I must say that there is still a great deal of confusion about AIDS even as to what it is. Is it infection with the virus alone or infection with the virus including some symptoms? As Voltaire said, "If you wish to converse with me, define your terms." In order to converse with the American public and educate them, we must define our terms. It is our hope that AIDS will be defined as HIV positive, with or without symptoms. We know of no other sexually-transmitted disease once in the body which requires symptoms to qualify as being a disease of the body.

Another important point in educating the general public about AIDS is to remember that for most Americans who do not participate in promiscuous sexual contact or IV drug use, they are not at great risk of contracting the virus. They relate to risk behavior much more than they do to risk groups, a term we find unnecessary and misleading. Because the most likely modes of transmission for the virus, sex, IV drug abuse and perinatal transmission are the least likely modes of transmission for a majority of Americans, the least likely modes therefore become the most important to them. This is the general public we are talking about. Consequently, we think it is wrong in any educational effort to dismiss discussion of uncommon methods of transmission. While they should not be emphasized, they should not be omitted either.

We agree with the premise that AIDS is generally difficult to contract. We feel presentations regarding transmission should relate to degrees of risk, and when we arbitrarily draw a line by the term "casual contact," we damage our credibility each time it is crossed. Beyond those basic definitions, the public is, also, confused by where the disease is today in the general population. There is lacking full public confidence in most education programs because there are so many contradictory statements by public officials and scientists as to whether this is going to be or is presently a heterosexual problem.

The public wants to know what degree of risks they face as a community from AIDS, and it is really nearly that simple. This is very important to the educational process because it is human nature to ignore those things which are unimportant. The public is asking if there is a parallel between where we are now heterosexually with AIDS infection and where we were in 1980 in the homosexual community. At present there are no accurate data which would answer this question. We do know where the disease was 5 to 10 years ago by those who have died or presently have what is known as full-blown AIDS or ARC, but we don't know where it is today accurately.

Prevalence and incidence data gathered at regular intervals will, also, let us know if our education programs are successful or not or if other public health measures should be implemented.

A concern we have about education is whether it is really working. We do know there was an overall increase in syphilis from 1986 to 1987 of 32 percent, and activities are occurring which dramatically contribute to the spread of AIDS, but we do know now quantitatively here in our Nation's Capital, for example, if they are increasing or decreasing, let alone if education programs are working. It is a city where testing targeted groups is warranted but a city like most others where even the word "testing" is somehow thought of as bad or at the very least as controversial.

In closing, Americans for a Sound AIDS Policy could be helped in its efforts to educate the general public and targeted subsets by this Commission in a number of ways. First, please act in a leadership role in defining AIDS. Logic demands it be HIV positive or infection by the HIV. Second, help discussion on modes of transmission by speaking in terms of degrees of risk and eliminate the term "risk group" so that we do not discriminate unfairly nor lose sight of how the virus is most often transmitted. Third, encourage the availability of rapid prevalence and incidence data so that targeted education programs can be designed and the results realistically evaluated by periodic data collection. Please help make this first and foremost a public health issue, and while eliminating the stigma of AIDS, also, eliminate the stigma of testing so that rationale discussion can be held from a medical perspective and successful test-linked education programs enacted.

We can influence the public to deal more compassionately with those infected. We cannot satisfy their need to know what degree of risk they face without testing, and without that information there is not an AIDS education program that will be effective for them or any subgroup which requires even moderate behavioral change. Thank you for this opportunity to express our views.

CHAIRMAN WATKINS: Dr. Holloman?

DR. HOLLOMAN: Admiral Watkins, members of the Commission, I would certainly be remiss if I did not thank you for the outstanding work which you have done and for the outstanding interim report, which you have issued, and I would like to further thank you for recognizing the role which community health centers play in this epidemic. I would certainly be remiss if I did not say, also, that this is a very distinguished panel, and I want to thank them for their efforts to compress their knowledge into 5-minute presentations which is a herculean task, and they have done an extremely good job. Being a bit verbose, I am going to go 6 minutes, with permission. Not really.

CHAIRMAN WATKINS: Thank you.

DR. HOLLOMAN: However, I do want to recognize, also, the help of David Cavanaugh who is the staff person to the Community Health Centers AIDS Task Force. Dave, I think is behind me. Dave?

We are some 600 centers located across the United States and its outlying territories so that we do have the opportunity to come in contact with, along with our colleagues, some 35 million people who perhaps are poor and minority or underinsured or uninsured, so that we have an extremely large and vulnerable audience. I think that the fact that we are now seeing a rise in the use of intravenous drugs represents an additional burden for community health centers. I might add that we are prepared to do a job so that there is no need to reinvent the wheel, although I would suggest that there is more work that we can do, even if we were adequately financed, which we are not.

We were originally put together to do a very specific job, and we have remained at a rather steady level of funding or the funding has declined. If we do what we are supposed to do now with AIDS, even in testing we would require additional funding because in order to counsel an individual prior to testing and then to give them the important information after the test results return, the important counseling after the test results requires more time than our productivity will allow.

We are, as I indicated, across the nation as a network, and we have had some interesting experiences. I will give you an anecdotal note or two about how we are beginning to run into the AIDS situation. We have, a nurse in Texas who is concerned that she has a full waiting room, for instance, of Hispanic mothers. They are seen every morning, and yet there are husbands there whose behavior the wives may not be aware of because of our inability perhaps or the need for special

training to link ourselves more closely to the culture it is necessary that we begin to train our staffs additionally so that they will not offend the very sensitive and very private and very important culture of this Hispanic mother, and yet still reach her family.

I think that we have evidence that there are certain cultures in which people are sharing needles using such things as penicillin and vitamins, particularly in border towns where these things are easily available. We now find that in that population we are finding the HIV virus, so that this is a new population that we have to look at.

We certainly have the problem that we have seen with immigration and naturalization. We have word that none of this information is to be used against these individuals, and yet we have word, also, that some 68 or more patients have been summarily deported after having been tested in violation of all the promises that have been made. So, it is this type of break in confidentiality, sometimes perhaps based on ignorance, but sometimes based on race prejudice. That is something that we are concerned about.

I am, also, concerned, and my paper may not show it directly, that some of the statistics that we rely on may be distorted because the poverty group is forced to use public testing facilities while the more affluent members of our society have the opportunity to have a greater degree of confidentiality so far as their condition is concerned. Certainly I know that in certain states now reporting is mandatory and that those who fail to report are subject to penalty. Yet there are persons who go to great lengths, understandably, who try to protect their confidentiality. So, these are some concerns that we have with reference to perhaps statistical distortions.

I have several recommendations in my paper here, but I would allow you to read those recommendations, and I would certainly give over the time to answering questions. The community health centers are more than 600 in number, are in every state, and we are already a network providing health care. Rather than have AIDS move into a categorical notch which will destroy the rest of the health care system, I think we should improve our health care delivery system by including AIDS as we include every other disease and adequate funding and care to all people. Thank you.

CHAIRMAN WATKINS: Thank you. I would like to commence the questioning on my left here. Ms. Gebbie?

MS. GEBBIE: One of the issues that we looked at a couple of times today with other panels is the interrelationship

of national effort with local effort. The panel that just preceded you spoke about how a national media campaign might underpin or overburden or do something to the efforts of local areas. I would be interested in comments on that issue from your experiences and perspectives, particularly if you have any awareness of how the ongoing federal media campaign may have been helpful or fit in or not fit in with what you are doing. If you are in a state that has had a statewide media campaign what that has done or not done for your local efforts, and I open that question really to any member of the panel.

MR. OFFUTT: I would like to respond to that. One of the problems of these national media efforts is still the lack of identification with the issue, I mean if you are looking at an ad campaign or a television PSA and you don't see people of color represented within that particular campaign, then it is difficult to identify with the issue and as somebody pointed out in the previous panel, to own the issue.

One of the things that I would recommend in terms of a national ad campaign is to use national media as a means of giving permission to local leadership, to local educators that it is okay to deal with this issue. I think, also, it would be beneficial if we could identify those national figures who have some credibility within the community.

With all due respect I think people, for example, like Walter Payton of the Chicago Bears may have greater credibility than some unknown minister in terms of talking about the AIDS epidemic and its impact on black people.

MR. GERALD: I would like to, also, comment on that. One of the problems that I have observed with the existing national media campaign is that it really, also, depends heavily on the voluntary cooperation of local radio stations or local TV stations who have the option to play the PSA's or not play the PSA's. You have a spotty kind of coverage of the campaign itself. It really depends on the volunteer efforts of those stations, and then again, the choice of those messages is, also, highly dependent on choices made by the local media community. In many cases the choices of messages will not serve the populations that really need to be reached within that particular community.

MS. GEBBIE: That is helpful. Does anybody else have a comment on that?

MR. MALDONADO: I think that we need to involve the local people. My experience in the community is, for instance, that if some of my friends know that there is going to be a program that I am going to be on TV, they all call each other just to watch, not so much to listen to my message but to see me

on TV. It provides me with an opportunity to get the message to them as someone they can identify with, that they can relate to.

MR. GERALD: I had one additional comment, if the rest of the panel would allow me. I want to repeat what I said in my statement, and that is that as a general awareness program, that national campaign strategy is important. I didn't mean to diminish the importance of that. I think though that clearly the message needs to be reinforced on the local level. The message needs to be constantly reinforced. You need that two-pronged approach. I would put considerable resources into community-based efforts as well.

MS. GEBBIE: As an observation, I would guess that your ability to reinforce it would be strengthened if you knew ahead of time what it was going to look like. So, you could do those tie-ins that we spoke about.

CHAIRMAN WATKINS: Excuse me. Were you here to listen to the dialogue of the prior panel? Were some of you here?

MR. MALDONADO: Yes.

CHAIRMAN WATKINS: Did you more or less agree with what that dialogue brought out in terms of were you to design a national system of education for the American public you may not have come up with a national mailer out of CDC but rather would have designed a variety of forms, flexible with heavy emphasis on regional and local development of some of those things to make sure that the outreach was effective? You might have some written materials, but you might even emphasize more electronic, other techniques. Would you agree with the general dialogue? I have asked them to come up with a strategy that would allow the planning for that to take place at really all levels, but certainly at the national level it shows sensitivity to community-based needs.

MR. OFFUTT: Absolutely.

MR. MALDONADO: In New Haven, the Women's Aids Coalition of the Mayor's Task Force on AIDS, put together 14 posters of black, white, Hispanic men and women of different ages. They did 14 different posters in English and Spanish. These are the type of materials that are going to work out there, and these are faces that people know and can identify with.

DR. HOLLOMAN: We had a meeting just this pasts few days of the AIDS Task Force of the Community Health Centers here, representing the various efforts around the country, and it was very striking how different the different parts of the

country are in the ways of approaching it educationally and the various needs.

One of the anecdotal points that came out was the fact that if you translate, and I heard it earlier in the panel, English to Spanish, you might miss it completely. Particularly when the reading level of the Spanish person may be lower, may be third or fourth grade or lower, so that we do have need to use such things as posters, such things as the local community can identify with, and the person who would certainly be best able to tell what is appropriate for that community would be the community-based organizations that are already there.

CHAIRMAN WATKINS: I didn't want to steal Kris Gebbie's time, but it was a natural follow on to the prior panel, and I just wanted to make sure that we continued that dialogue. It is important that we understand the best means to talk about some kind of a national education effort to make the entire population aware, not to mention the intervention needs in the non-mainstream population which is out there which is most difficult to reach many times. That I think it is important that we understand what best can be done there and that we not repeat past lessons we should have learned on how to best have an effective outreach program on the national level going down to the local level.

MS. GEBBIE: At least one of you mentioned technical assistance. I think Mr. Stein particularly mentioned it, but it was a piece of, a couple of presentations, and you also, mentioned problems of relationship with local health departments or state health departments not giving you funding. One easy answer, I think, would be to say, "Fine, we will just tell CDC or somebody like that to be your technical assistance place." That would get to be an awfully big CDC given how many of you there are. That may not be bad. The two pieces of my question are one, can you be more specific about the kinds of technical assistance you need? Is it technical assistance about exactly what is this infection or is it technical assistance about exactly how do you do a media campaign or what is the technical about which you want assistance. Then second, in the best of all possible worlds, if we could fix the problems that technical assistance come from a local resource that has it, like a local health department or state agency or ought it come nationally? What is your sense of where we ought to look for that resource, to build that resource?

MR. STEIN: I don't think, of course, there is any one simple answer because I think it really depends on the specific needs of the group that we are talking about. When we look at a national response, I think what we are hearing today is the importance of it trickling down so that it is implemented on a local level.

MS. GEBBIE: I prefer some stronger word than "trickle" by the way.

MR. STEIN: I will ditto that. When I look at technical assistance, I am concerned that in essence many of the groups represented here, have survived. GMHC, at which I was a volunteer when I lived in New York a number of years ago has survived. I feel as if my organization has literally just gotten through a survival period because we were trying to balance a million dollar budget with not a large administrative staff. Really none of our funding pays for even a bookkeeper, and so, how do we manage that; how do we, needing to learn how to go after more money, technical assistance and writing proposals, technical assistance in designing programs? A lot of that has been received from a number of different agencies. For example, the National Institute on Drug Abuse, NIDA, has come through our community with a 2-day workshop on community collaboration, building public health awareness campaigns. It was a nice effort. The concept was excellent. However, they were in and out in 2 days, and the amount of follow-up available is going to be rather minimal. Again, I see less of a need perhaps for the direct delivery to happen from a national level as opposed to perhaps funding be available.

Now, National AIDS Network, NAN with which Gil is affiliated, is in the process of gearing up for that. We are a member agency of NAN, and I look forward to the type of technical assistance that perhaps they would be able to offer us, such as a consultant to come in for a 3-day visit to assist in our reorganization because all of a sudden we have a $500,000 contract which we need to get in place immediately. So, that is how I would see it for my specific need.

MR. OFFUTT: I would echo what Mr. Stein has said but would, also, add that if we are looking at setting up community-based models to respond to this epidemic then we are going to have to provide some assistance to some of these communities in terms of just how to get organized, who to get training, how to get training, how to deal with some of the variety of issues related both in terms of AIDS education and if they choose to provide services, the delivery of services as well. So, it is going to be that kind of assistance, as well, plus what Mr. Stein said.

MR. GERALD: I am Gil Gerald, of course, Director of Minority Affairs at the National AIDS Network, and the National AIDS Network came into existence a little over 2 years ago. It was brought together by the oldest AIDS service organizations in the country, including the Gay Men's Health Crisis and a number of organizations in California and Massachusetts. The five largest organizations brought us together to address this very issue of providing and sharing information with the emerging

organizations that were developing across the country, including Topeka, Kansas, for example. Interestingly enough we are able to provide direct technical assistance to whole communities with private corporate support. We have gotten private support from major corporations in this country to provide technical assistance to community-based organizations in five cities in this country. We have a Field Resources Program that makes experts available to those communities.

As funding becomes available, this can be expanded. The first national conference of the National AIDS Network (NAN) will take place in October, and this conference will focus on administrative skills. We hear clearly what our community-based organizations, some of which are represented on this panel are talking about in terms of their need for support around administrative skills and fund-raising skills and management skills. Certainly NAN is a resource that is already there that is evolving very fast. The National AIDS Network now represents over 400 community-based organizations We are producing technical assistance packets, and they are currently being distributed.

DR. HOLLOMAN: May I? I am Dr. Holloman, and we need assistance in making sure that our health workers and that our community boards and that our patients are educated. We need assistance in teaching them. We need assistance in assisting our physicians and our nurses in protecting them from burnout, particularly when they have to go intensely one-on-one with reference to a recently HIV positive individual, and then to carry them over an extended period of time. I think that this is the type of technical assistance that we need. What is it we are to say to a person who is to be tested who has no knowledge? We have a community that has a rather low level of knowledge with reference to AIDS, and now that the incidence is beginning to plateau out in the gay men's area, I think that the fact that now with the drug abuse being more prominent and perhaps increasing that we need to recognize that the behavior of a drug abuser is quite different that of an intelligent, educated gay person. The efforts to change the habits and behavior in this community are quite different, plus the fact that these individuals are already directly in violation of the law, and that we have a national lack of concentration, perhaps to some degree, on the drug problem that we have.

Now, we see the victims of the drug problem, and this is a portal through which we anticipate transmission through heterosexual means into the community. So, we do need educational help and technical help to make sure that we know exactly how health workers will be dealing with this problem. They need it, and they need it on a regular basis. It is something that has to be reinforced. Thank you.

MR. MALDONADO: I hear numbers being thrown around. When I heard Mr. Smith speak about a million dollar budget, it took me back because Hispanos Unidos Contra SIDA/AIDS has a budget of $27,000, and that is to hire a director, a part-time secretary, a storefront, utilities, etc. We need funding, and again, we need funding to come the local level. I am very concerned because in the State of Connecticut over 52 percent of the cases with AIDS are among blacks and Hispanics, and the information is not reaching blacks and Hispanics. We need to get that information out.

MR. SMITH: One thing that may be helpful for any AIDS organization, particularly a new one is to understand the complexity of organizations within the federal and state governments that deal with different issues related to AIDS. It is a maze, and it is very difficult to unravel and understand, and so, if there were a guide to getting through the government for AIDS organizations it would be a great help.

DR. HOLLOMAN: Absolutely.

CHAIRMAN WATKINS: Dr. Lilly?

DR. LILLY: My first question has to do generally with the idea of evaluating what you are trying to do educationally. I will ask Dr. McKinney to start because I know that GMHC has made some efforts to evaluate their educational materials, and given those efforts, Dr. McKinney, do you think that your efforts have anything to do with the apparent amelioration of the transmission rate within gay men?

DR. MCKINNEY: In the face of crisis, Gay Men's Health Crisis, met the crisis situation in a crisis modality. We did not have models, educational models to draw from. The first educational efforts were what felt good, what felt right, what people felt good about. You are so right that we had to develop strategies for determining if this is good, what part of it is good; what works; what doesn't work with regard to our AIDS prevention programs, our volunteer training programs and so on. We knew that parts of it worked. We were not able to identify which parts worked and which parts might be discarded. Within the past couple of years, we have been aggressively evaluating our programs to determine what parts are more effective and what parts are less effective so that we can more efficiently do the job. We do have some empirical evidence from the so-called "800 men study" which compared several different educational interventions to determine the relative effectiveness of each, and we have determined what materials and modalities are most effective over time, as well. Currently we are concluding a 2-year program that has been funded by the Centers for Disease Control. It is a risk-reduction program and is measuring relative effectiveness of different educational interventions and

then, going beyond that, testing them in other locations to determine whether or not they are effective in those locations as well. Examples are the Riker's Island program and the residential treatment programs. Our materials have been taken out to Columbus, Ohio, under the aegis of the Ohio Department of Health to be tested in Columbus, Cincinnati and Cleveland so that we are getting empirical data from those sources. It is a long time coming, but that part of the program is just now coming into being. We now can predict an outcome when we initiate a program. We have not always been able to do that.

MR. GERALD: Dr. Lilly, I would concur with an earlier statement made by Mr. Maldonado that we need to be cautious about the use of consultants in education efforts, but I would like to point to the work performed by one that points to a great need. There is one really very nice report that was produced by a group called Polaris in San Francisco which established baseline data about behaviors, attitudes and knowledge in one particular community, and this was the black community in the San Francisco Bay Area. Part of the problem with evaluation is that in the beginning, in the crisis situation, there was no baseline data from which you could begin to measure change. I would encourage the Commission to recommend that there be expenditures to establish baseline data around behaviors, knowledge and attitudes in specific communities. You cannot take a Harris poll of the country and really get a sense of what is happening in either the gay community, the black community or the Latino community. You need to really talk about specific studies that address specific groups. Those studies really are an aid to community-based organizations in establishing goals.

MR. OFFUTT: I just wanted to add that I think we are just now beginning to see specific efforts at targeting minority populations in terms of education models, and as has been the case with regard to the gay community, we are going to have to work with these models for a period of time before we can begin to assess their effectiveness. We have found out, however, in terms of our work in Chicago that it is important in terms of how the information is given to the community. It is important in terms of whether or not the information is provided in a language that the community feels comfortable dealing with and in a setting that the community feels comfortable being in. I mean all of these things have to be taken into account.

MR. STEIN: Dr. Lilly, I would like to say with respect to that evaluation, in terms of a national response, most of the work that we have seen results and some good action is coming from the National Institute on Drug Abuse. They have, to me, been in the forefront of funding both education, training and, also, research efforts with respect to taking a look at what is happening with the IV drug-related population. We are currently

starting up an evaluation component for our street outreach program to evaluate how effective a specific type of intervention is to impact upon IV drug users. It is a 3-year study. So, we really won't be seeing results for quite a while, but I think it is those type of efforts that we would like to see more. What is even more exciting about it is really taking Gil's comments one step further in allowing community-based organizations to participate very actively, not really be attached to this research component, but really be one of the centers of it. So, for example, we are the research site. I am the project director for that. I am responsible for assisting in that whole process. It gives my organization and our community a feeling that we are making an impact and that research is accompanying it and that it is doing something. I think NIDA is right now the only agency that I have worked with on the federal level that I have seen that much of a response, and I am sure it is happening on other levels, but they have been the most vocal.

DR. LILLY: I suppose another aspect of this add is to what extent does sexually-explicit education play a role in what you are doing. I am wondering this particularly because of the Helms Amendment that came up and was, in fact, extensively modified before it was actually passed. I am wondering if that is providing barriers to your educational process, the fact that as far as I can tell, one can tell people what not to do sexually but one cannot tell them what is still left to do.

MR. MALDONADO: Let me say something about that, and I will speak about the Puerto Rican community. When you speak about the Puerto Rican community and when you do AIDS education, you cannot talk to the Puerto Rican community about AIDS education unless you speak about the culture. For many of us the word "condom" is something new. Many of us have never seen a condom. And now, with AIDS, we are being told that we have to use a condom. Materials explaining the necessity of using condoms must be very sensitive to the culture. Sex is not something that is spoken about in our homes. Now, with AIDS we have to begin to teach our people that we need to speak about sex. This is very complicated.

MR. OFFUTT: I think what I have found in terms of the black community is that since, let me back up and just say in terms of black men specifically and young black men, the teenage population. Sex is a big part of their validation in terms of who they are. So, we just cannot go out and there and say, "You cannot," without providing some alternatives in terms of how you can and how you can do so safely. Yes, the Helms' Amendment is extremely troublesome to us in terms of limiting our ability to be explicit, but on the other hand, we have had to be explicit because the language of the streets which these kids relate to is explicit. You have to talk in terms of where they are at, if you expect to reach them and to have an impact on them, and so, we

have tried to do that, knowing that we are in jeopardy in terms of the Helms' Amendment but, also, recognizing that getting the information across to this, very vulnerable, portion of our population is crucial.

DR. MCKINNEY: The 800-men study clearly established the fact that an educational intervention that utilized visuals as a part, is more effective in modifying behaviors from high risk to low risk than an intervention without the use of visuals. The Helms' Amendment was targeted rather at our safer sex comics that were produced by the Gay Men's Health Crisis in New York. That there is as much diversity in the gay population as there is in the general population, and there is no single piece of literature that is appropriate that addresses all levels of that population. It would be inappropriate for us to give a piece of literature in Chinese to the English-speaking population, and we don't, but we do publish in Chinese for the Chinese population. Within the gay community there are those individuals who respond more effectively to what cartoon art. The power of cartoon art canotn be discounted. Political cartoons are a very, very strong format of conveying a message that might take a whole typewritten page but can be communicated very powerfully in a political cartoon, and we use cartoon art to convey a very important message to a particular audience and we have found that that means of communicating is the most effective means of communicating with that particular audience. Our critics who feel that we should not use the safer sex cartoon are asking us to abandon really a segment of the population that responds effectively to that form of communication. We cannot abandon that population, and we will continue to use the kinds of materials that are most effective for certain populations.

MR. MALDONADO: I would just like to support what Dr. McKinney said because cartoons to us are very important to us. We love to read cartoons. So, when we decided to do the brochures, we used the cartoons, knowing that our people were going to enjoy them.

DR. HOLLOMAN: Dr. Lilly, I think that we do have a problem, and we will continue to have a problem that is different from the gay man's problem. I think that the same means by which we reach that population cannot be used so far as the IV drug user is concerned. It is a completely different culture and to recognize that this is where we are woefully short and the IV drug problem is not a new problem. The controversy around it is not new, but the solution seems to defy anything we have come up with. I think the experiment that we are doing in New York with clean needles is an interesting one. The experience with bleach as a means of sterilizing dirty needles is an interesting one. The experience that we are seeing on the border with the use of needles is an interesting experience, but we need to go straight to the drug-abusing population and not have barriers and not to

isolate them. They are there on the corners. If you ride down any street, I can assure you that you will see parking tickets on every illegally parked car and standing next to the illegally parked car you will find the drug pusher and the person who is buying the drugs and the person who at that point on that street corner could, also, receive perhaps some education. Just like we can pass out tickets, so it is a need to recognize a problem, not trying to ignore it, not trying to make sure it will go away because the cost of drug abuse in this country, and I am sure you know better than I, is enormous. We still are suffering from what I call the ostrich syndrome in which we would like to ignore it because those people don't count. We need to get over that approach because those people are a time bomb which may threaten to destroy much of our society.

MR. GERALD: I think the problem with the Helms' Amendment that you cannot legislate effective messages on a national basis. These are local decisions that have to be made by the people who are in touch with the community and understand the kind of message that will have some effect on the people that they are trying to reach. You know, some of the most effective programs that the community-based organizations are involved in are street outreach programs. Street outreach programs, put people like our reformed IV drug users on the street, who can speak in a familiar language to their peers. An abstinence or "Just Say No," or mutually monogamous message is not really going to have very much effect in stopping the spread of the AIDS virus. Stopping the virus is what we would like to do. There is a whole body of public health information that supports the idea that you have to give people options. People have to understand what their options are. If you give them a very limited number of options, then you limit the ability for people to change behavior. You have got to give people all their options, and sexuality, as we well know, does not begin and end with penetration. There are a whole range of activities that are involved in sexuality, and people have to understand that this thing that is very important and personal to them does not come to an end and that they have options, clear options.

MR. MALDONADO: There is another issue. All of us want to be able to do things for the addict. I think we need to allow the addict to be part of the process. I heard the word "expert" being used here before, and I am very concerned when I hear the word "expert" because many times those are the people we call upon. We gather experts. There is a problem in the addict community. Many times we respond by drafting materials for the addict. The addict looks at it, and its like reading a foreign language. They cannot relate to the materials. Its better to get the addicts themselves to meet and come up with the materials, and the text. We should help them do it.

MR. STEIN: I would like to go another step with this. There is so much focus, especially around the Helms' Amendment issue on the impact of educational materials. I think frankly, the answer is not so much in posters and pamphlets, which are clearly important, but they are not going to change behavior. If we have a limited amount of money and resources to allocate, let us put it into people. Let us put it into former users out on the streets. Let us us put into peers educating peers. Let us translate it into action. A brochure being sent out to an individual will have a minimal impact versus a peer, whether it is a teenager, a student, a former drug user going out to the area where he or she used to cop drugs and being able to give that pamphlet to somebody and sit and talk with them. The pamphlet, I think, is a vehicle. Frankly giving out a condom has even more impact because there is a gift relationship. There is a process there where we are literally handing something to somebody, and it is free. It doesn't cost anything and no judgment involved here. That is where education happens. We have had four outreach workers. Four outreach workers will not make an impact in Baltimore City that has over 30,000 known IV drug users. That is minimal impact, and that is, I think, where we need to see a lot of our educational efforts being directed.

CHAIRMAN WATKINS: Dr. Lee?

DR. LEE: When I first started here about last July, with the lady who was working for me at that time, Ms. DuFour, we started a file on community-based organizations. It ran out into the hall, and through the next building. She left me to go to work for Admiral Watkins and Polly Gault, and that file is still sitting there. Now, I am trying to get a handle on organization. Mr. Gerald, you said that you have 350 organizations within your network. Dr. Holloman said that he had 600 organizations.

DR. HOLLOMAN: We have 600 community health centers which are community-based across the United States and Puerto Rico.

MR. SMITH: Specific to AIDS?

DR. HOLLOMAN: Not specific to AIDS. This is a primary care organization, and that is where I think that AIDS needs to be confronted. That is where we are the frontlines.

DR. LEE: I understand that, and when we had our first Commission meeting in New York we immediately went to the experts and Tim Sweeney and Richard Dunne at the Gay Men's Health Crisis Center organized one of our sessions. We met 13 organizations there in 2 hours. So, I am wondering if you couldn't get together. You would be a sufficient political

force. It is hopeless going through the bureaucracy, even finding out how to get through the bureaucracy. We are aware of that. One of our main jobs is to try to find ways for you people to get through the bureaucracy faster. We spent a terrific amount of time with FDA, and so forth. We found out that they were not the villain, really. It is the people who are putting constraints on them that are more the villain. Anyway, sir, could you respond? Is there any way to get all of you together? Is that even a good idea? Wouldn't you be pretty amazing as a political force, if you did?

DR. HOLLOMAN: I would like to respond. We do come together, but we have not met personally. We depend on his organization for much of our material. Certainly we didn't rediscover the wheel, but we are hopefully learning to become a political force. We have been during the past few days lobbying, I am sorry, educating --

(Laughter.)

DR. HOLLOMAN: -- our representatives with reference to what community health centers do, and how adversely AIDS can impact our ability to exist, but we certainly have and do need or would like to be able to cooperate in an educational effort to make sure that Congress knows just how important this problem is.

MR. GERALD: We come together under the National Leadership Coalition on AIDS. We are both members of that body. Certainly within that context we have worked together. I concur with much of the remarks that you have made. I am on the advisory committee to the US Conference of Mayors. They distribute CDC funds to community-based organizations, and in fact, Mr. Maldonado's organization did get some funds through the US Conference of Mayors and I just want to point out that that is an example of direct funding to organizations that bypasses the states, and I think that that needs to be expanded. Some of the organizations that were funded in the last go-round, if I recall, were community health centers in the South and I think in the Midwest. I concur that in some parts of this country where there are no community-based organizations that are AIDS specific, I have advocated that community health centers are key. They are meeting the primary health needs of particular communities, and I have seen some very good proposals from these organizations. In fact, I believe I saw proposals that address migrant workers, and I have seen proposals that address the black community in either Mississippi or Alabama. I think one of those proposals was funded. So, there is this dialogue that is going on between us, and it is being strengthened.

DR. HOLLOMAN: There is a real interdependence, and it is there. I certainly have to acknowledge the efforts of the Gay Men's Health Crisis Center, as well as the National AIDS

Network, because much of the work that we are now doing has been as a result of their planning and pioneering efforts. We are now, I think, in a position as a viable operating organization which can be more effectively used. We do exist in every state and in the territories so that we are providing primary health care, and we do have basic position papers with reference to AIDS testing and counseling, and we really feel that great funds are needed, but this is not a plea for funds. This really is a plea for cooperation and for education, for technical assistance and for frank recognition. I think that we are achieving that.

CHAIRMAN WATKINS: Are we seeing development of a loosely configured structure being built that is not connected by any kind of rigid structure? Community-based organizations are doing their things, and we are beginning to see the National Leadership Coalition on AIDS, the National AIDS Network, the AIDS Action Council with their recent report? You know, there are a lot of activities going on. The linkages are being made. Is there anything that is building that is clear enough to identify, say those that might have the greatest impact that now couple together at national policy level or state policy level down to regional, local? We are beginning to see those in such a way that there could be an identifiable, albeit loosely configured structure to the national system that is actually being built? You are doing the work out there that you have to do, and so, aren't the linkages and the interchange in communication is beginning to flow?

MR. GERALD: I think the answer to that is yes, and I think that some of the organizations that you have mentioned are clearly within the league that we are talking about. I would add that there is room for some emerging organizations that I would advocate be recognized. For example, I was just in Los Angeles for a National Symposium on AIDS in the Latino Community, and this brought together professionals from the Latino community from across this nation. They have decided, to organize a National Latino AIDS Organization, and I think it is important that when we look at the history of the response to AIDS in the Latino community that we see the emergence of this organization as an important ingredient.

So, I don't think that we are going to close ranks behind already established groups and say that these are the identified groups. We need to be open to the emergence of groups. It is not an and/or situation. For example, the Latinos clearly are part of the National AIDS Network, and they are part of the National Minority AIDS Council which is an organization that has presented testimony before this Commission.

DR. HOLLOMAN: They clearly are a part of the network of community health centers. They are significant in our ranks.

MR. MALDONADO: I, also, think that the hierarchy was there before these organizations came into place. There was a problem, and the problem was that the traditional CBO's that were out there were not meeting the needs of education, basic education in the community. This is the reason these new organizations came into place. Some community-based organizations, just don't want to touch the issue of AIDS.

MR. OFFUTT: I think that has, also, very much been the case in the black community. It is fine to provide health care services to people who have been diagnosed either with AIDS or HIV-related illnesses, but to be able to discuss sexual behavior issues is a much more difficult proposition, and if the person responsible for putting out information is uncomfortable in terms of dealing with the myriad of sexual behaviors out there, that he or she is going to find, then the quality of that information and therefore the impact that that is going to have in terms of changing the behaviors, the at-risk behaviors, is going to be questionable.

MR. MALDONADO: I think we need not to forget that at the beginnning it was identified as a gay disease, but now it is no longer a gay disease. Now, it is a disease of blacks and Hispanics. The numbers are going up, and we are not getting anywhere.

MR. SMITH: Just to respond to both of you, I think there will be a handful of national AIDS organizations that emerge in leadership roles, but to unite, to become a political force, as such, the focus of a non-profit dealing as a CBO is really education and caring for those infected and not lobbying as such. They are nearly all C3's, and you are not going to have many 501C4 AIDS organizations, and that may or may not be good. I don't know. That is one of the difficulties, just the legal thing.

DR. LEE: This kind of fragmentation makes your case more difficult to build. Each one is an excellent case, but when you have over 1000 cases, there is so much information.

MR. SMITH: Also, as the disease spreads, geographically and more into the heterosexual community there will be more AIDS organizations that will come up. Some will join others or some will form other coalitions, and I guess it is maybe a parallel to have a representative congress. There are a lot of different viewpoints, and hopefully, it gets worked out.

DR. LEE: Could I bring up one other point? We have supported in our last series of hearings the Community Research Initiative in New York. To me it has seemed like a very worthwhile thing to support. I know a lot of the people in it. Are you people involved with that?

MR. OFFUTT: No.

DR. MCKINNEY: We are.

DR. LEE: The Gay Men's Health Crisis is, but I would think it would be terrific if Dr. Holloman was involved in it.

DR. HOLLOMAN: Actually I am very sincere when I say that I have been depended on, through the early years the Gay Men's Health Crisis Center because they did at the time have the expertise and some limited resources. The limited resources that we are now facing are really in our own backyards, and our system itself is now threatened because of the limit on resources, and because of the different needs in our patient population.

DR. LEE: I want to tell you there is money coming down to the CRI. It is there, and it is coming down through the NIH. So, there is a carrot there.

CHAIRMAN WATKINS: Dr. Walsh?

DR. WALSH: I think the fragmentation has been harmful, but I would say that the AIDS Network is certainly to be complimented for the political clout you have already demonstrated, my heavens. I have never seen anything hit Washington so hard and so fast in my life, and I have lived here most of my life. The concern is that when anything hits that fast, the attention span of Congress is very short. You do run the risk, I think, of peaking and then if you are fragmented, as Bert says, and this is where I agree with him, you do run the risk then of losing constructive influence. One of the problems I think has been that the plethora of bills that are coming out are much more politically oriented and confused, rather than purposefully oriented in a way in which you would like them to be which is the part again that I agree with him on. You have to prioritize among yourselves the things that are most important. I am particularly interested in your thoughts on the primary health care center network. Really when these were started they had much the same type of scattered clout, until finally they became a pretty accepted way of delivering overall health care so that you feel sufficiently confident to sit there and say, "Oh, yes, we didn't know what to do. We turned to the Gay Men's Health Crisis, and we asked them what to do," and you knew that in no way would that lessen the influence of your network of health care centers. I wonder for the long haul what your thoughts are as to whether an umbrella like that might not in the long run be important to you because there are so many ramifications to AIDS, first of all, as a disease, and I hate to call AIDS a disease. It is a wrong terminology, but it ties in with so many other things. As the Admiral pointed out in his report, it ties so much into an IV drug abuse program which many people will psychologically and mentally just separate off from

AIDS because they will say that there is only a small percentage that are involved with AIDS.

We talked about environment and improving housing to increase self-esteem among the poor. In effect, we are talking about a mini war on poverty as a real weapon in this whole picture, and I wonder if there isn't a way or what your thoughts would be that what you are really talking about is primary health care education expanding into a new disease. You have a built-in base of support for primary health care particularly among the minorities because it is frequently the only health care they get. It is the only access they have, and I just bounce that out for conjecture to see what you think as to whether that would strengthen perhaps what you could do. Again, I am talking in the long term because as Beny Primm said, he is a pessimist and so am I, "AIDS is going to be with us for a long, long time," and you are never going to maintain, and I don't care whether it is AIDS or leprosy or what; you are not going to maintain peak interest in one disease forever. There has to be an umbrella, and I just see the primary health care units as a great opportunity because you have stood the test of time, and I would like your opinion.

MR. OFFUTT: I, for one, thinking in terms of our experiences in Chicago, went to the primary health care providers initially back in 1983, trying to get them involved, and I think one of the problems has been that at that time they were not interested.

DR. WALSH: That is right.

MR. OFFUTT: Yet, we were seeing the numbers of cases coming out of the black community, and we couldn't sit back and say, "Well, you know, we cannot wait until you all decide that this is a significant problem."

DR. WALSH: I know that.

MR. OFFUTT: Unfortunately, this still is predominantly the case in the city of Chicago. We still cannot get black physicians, black nurses, black medical professionals of any type in numbers to get involved in this issue. Occasionally one or two might be involved in terms of primary patient care. We have currently two doctors that we make referrals to. We have the involvement of a small group of nurses who are connected with the Chicago Chapter of the Black Nurses Association, but that has been it, and one of the biggest problems that we have seen in terms of the health care group system affecting the black community is that if you have AIDS and are being treated in one of those facilities, your treatment is not all that great.

DR. WALSH: Is the expansion though that we are considering in our deliberations of the National Health Service

Corps, is this more logical or likely to take place if it is for say a primary health care center? Would you be willing to give the primary health care groups a second chance?

MR. OFFUTT: I am always open to giving them a second chance.

DR. WALSH: I am just thinking of a way in which we can get as much value for the dollar but, also, a sustained program.

MR. OFFUTT: I think we recognized initially, and I certainly recognize that we are not able to do the entire job ourselves.

DR. WALSH: They didn't know. They were as ignorant as we were.

MR. OFFUTT: I think the door has always been open in terms of working with that. We have done a number of educational presentations to primary health care providers.

DR. WALSH: You see, I am just wondering with the reluctance of the doctors to participate, if they are lured into participating in something broader than just taking care of AIDS patients, in a sense you have got them trapped. I mean they are in there, and they have got to take care of them, too, else they cannot participate.

MR. OFFUTT: But unfortunately, many of them are operating in that broader context and still are having difficulty taking care of those patients. That has been part of the problem.

MR. GERALD: I would like to illustrate how these problems actually manifested. In reviewing proposals, let us say for a particular city, I do recall reviewing proposals for community based organizations in New York for efforts targeted to minority populations. There were a number of proposals that came from community health centers, and there were proposals that came from community-based organizations that were already doing AIDS work within minority populations. We are talking about a small pot of money. The ones that were coming from the community-based organizations like the Kupona Network were demonstrating that they had some experience, some commitment and some understanding of issues. The proposals from the community health centers reflected the need for resources to educate staff. Now, what do you do in a situation where you have a small pot of money and two organizations? One wants to educate staff, and one already has the experience and the sensitivity and the knowledge to undertake prevention programs in the community. It is a very difficult question because we recognize that the community health

center is an important resource in the community. You want to be able to say, "We want to fund both." We want to provide the education right away because it is needed. HIV is being transmitted as we speak. Do you take that resource and give it to an organization who will then have to reapply for funds after first giving information and knowledge to then go and do education. This is an example of the kinds of difficulties that we are operating under.

DR. HOLLOMAN: I think that is very true. There has been perhaps a reluctance on the part of some black physicians to participate in the care, treatment, and diagnosis of AIDS patients. The same has been true with the majority community as well, and the majority organizations have, also, similarly tried to walk around it, to ignore or certainly not participate. The debate continues to rage as to whether or not it is an unethical act to refuse care to an AIDS patient, and we continue with some of the unresolved philosophical positions. It is important, and we are back here again after 20 years with a group of community-based organizations which is really concerned with the accessibility of health care, not only to the poor but to all Americans. We haven't really made much headway in that direction because we have gone off into many special interest directions. When AIDS, as you suggest, Dr. Walsh, may well be just another categorical disease or special direction 2 or 3 years down the line, and there may be other things that are more sexy, more jazzy. But as Beny Primm says, "It looks like we are going to be here for the long haul with AIDS," then this might be an excellent opportunity to address our health care delivery system and to eliminate some of the inequities.

DR. WALSH: To me it just presents itself as a potential resource pool.

DR. HOLLOMAN: Absolutely.

DR. WALSH: All of us have to take a look at our budget deficit, and we know that we are not going to get everything we want. How are we going to be able to make the best use of it and still answer the needs of those of you who have dedicated so much time to developing the AIDS network and the AIDS educational backgrounds that you have. This is where I do agree with Dr. Lee, and I am concerned that bureaucrats are all the same. The standard answer when you get fragmentation is there is no way we can oversee this or there is no way we can determine whether they are doing good work or not because there are too many. They like to deal with the familiar if they can, and I am searching for a way to find out how we could do it because I do think that we have got to find an answer for the AIDS problem.

MR. GERALD: Clearly in terms of the services that we provide, community health centers are part of what we would consider as organizations that we would serve. So, therefore, in terms of the services of the National AIDS Network clearly community health centers are part of it. If we get a request from a health department, we respond. It is not just the traditional community-based AIDS service organization that utilizes the services of the National AIDS Network.

MR. OFFUTT: I would, also, like to add that we have been providing a number of inservices to health care agencies at the local level and, also, referral services for them in terms of clients that they may come in contact with. What concerns me, however, is when I have to provide resources to a person infected or impacted by HIV who has been to several doctors in the community, and all of them have stood across the room from him saying that we cannot treat you or we do not want to treat you. That concerns me.

DR. WALSH: It is inexcusable.

MR. MALDONADO: More serious for Hispanics is that although the services are there, there is no Spanish-speaking staff to give the services. I am speaking specifically about testing in the State of Connecticut. Of the state health facilities that offer testing and counseling, not one has a bilingual person to provide counseling. So, how are you going to refer someone to testing if there is no one there who can speak to them in their own language?

CHAIRMAN WATKINS: Ms. Gebbie?

MS. GEBBIE: It really fits in quite well as a follow on, I think, to what Dr. Walsh has asked, and may be something you would want to jot some thoughts down on if we are tight on time here today. Late yesterday we explored one of the implications of our penchant for disease of the month club organizations, and that is that with all the attention to AIDS, our attention to other sexually-transmitted diseases has waned, and now some of those diseases are on the increase. You have gathered together many of the organizations sitting at this table now around a sexually-transmitted disease. It is, also, transmitted by needles, but it is sexually transmitted. What observations would you have on the long run of maintaining AIDS networks and AIDS organizations as a separate disease oriented resources, or the possibility of linking in with those organizations, such as VD action councils or the Physician Health organization we heard from yesterday and others around the whole cluster of diseases where a common effort might over the long run accomplish something? You, also, lose some identity in that. So, it is plus and minus, but I would be interested in observations.

MR. GERALD: In terms of the minority community, I had the privilege of speaking before the Provident Clinical Society in Brooklyn which is a chapter of the National Medical Association, and they specifically invited me to speak to what can the Black Community learn about the gay response to AIDS. One of the things that I pointed out was basically what I said in my statement. When you deal with this particular issue of AIDS, you, also, address some of the other underlying social issues and economic issues in the community. I think it has been shown that infectious syphilis is way down in gay and bisexual men as compared to the rise in infectious syphilis in the general community. When you deal with this issue of AIDS and you mobilize your community around AIDS, it doesn't mean that you abandon the other issues. I mean it is a way of addressing teenage pregnancy. It is a way of addressing IV drug use. It is a way of addressing the high rates of STD's in our community. I think that this becomes a vehicle for addressing all of those other issues, and we are very much trying to make that clear, When you are dealing with AIDS, you are not dealing with AIDS in isolation of these other health concerns.

MR. OFFUTT: I would like to re-emphasize what Gil has said. If we were to do that, now, we would not be in business because it is a broader issue than just HIV infection. We do have a sexually active teenage population in Chicago. We have an exploding teenage pregnancy problem. We have an exploding STD problem which includes syphilis and all these other things which tie into sexual attitudes within our community which tie into not talking about sexual diversity within our community. All of these things are linked, and so you cannot just talk about one. You have to talk about all of it.

MR. SMITH: What you are suggesting I think is very good. AIDS though is such a problem and so new and needs so much education that the focus is probably going to remain AIDS for some time. What may help organizations like these, certainly ours is if you or the Public Health Service or CDC could give direction for a long-term plan of reacting to this epidemic and other sexually-transmitted diseases so that people in their planning can think far enough out to include that sort of issue. I think we need some leadership, and it needs to come from somewhere, and it doesn't seem to exist right now.

CHAIRMAN WATKINS: We have time for one more response, and then we are going to have to close out the panel.

MR. STEIN: I was going to say that many communities prior to AIDS never even had an organization focusing on health-related issues, such as sexually-transmitted diseases. I think AIDS has pointed out that deficiency in the past, and I note that the specific name of my organization doesn't even have the word "AIDS" in it. We focus on AIDS now. I hope that we

will be able to broaden our mission so that when AIDS, hopefully is more in control, we can expand so that we can provide that type of service that is clearly missing at this point. Communities do not very often have that widespread level of response to health-related issues. Sometimes they are very targeted in specific diseases. I think we need to take advantage of what we are learning in terms of our deficiencies with respect to AIDS and carry that forth into the future.

CHAIRMAN WATKINS: In honor of Dr. Primm, Dr. Holloman, you can have one more comment.

DR. HOLLOMAN: I will tell him in absentia I made a point.

CHAIRMAN WATKINS: He would have been pressuring me anyway.

DR. HOLLOMAN: Thank you, Admiral Watkins. I think that the fact that there are many Americans without access to health care of any kind is a very important point. The fact that now we are concerned with a health issue, AIDS, that we have the opportunity to consider AIDS along with primary access to health care for all Americans, and if we can come out of this Commission with that, we have made a giant step forward.

CHAIRMAN WATKINS: I think we are all very sensitive to that, and certainly I think you can see in the very early stages of building a national strategy, we are turning over the rocks of the national health care delivery system in a way that I hope will lead us to a better way of life in the country. Even though we are doing it through the HIV lens, at this point in time you can see within that just in the health care delivery recommendations we have made already of a system that simply was not ready in any way to deal with a crisis. Certainly one of the great lessons learned out of this epidemic is going to be a much more streamlined, modernized concept of emergency health planning in this nation so that when the button is pushed we have networks we don't want to lose. We don't want to lose the linkages, and we have seen what you have had to do. The community-based organizations have been the stalwarts. They are the frontlines of defense right now and have done so much on their own. We don't want to lose that networking. So, we are building in the nation perhaps a whole new concept of integrated health care delivery where we can optimize costs and we can do things that we haven't done before. So, we don't want to lose the momentum.

I want to praise Mr. Gerald. We talked about fragmentation, but he has pulled 300 entities together. That is no mean task, and they all talk to each other, I will bet, and that in itself is an incredible task. So, I think that I would like to look at this optimistically. While the HIV epidemic is a

tragedy and while we must deal with the immediate sorrows of those that are afflicted and those to come, we, also, should not lose this as an opportunity to turn the nation around in our sensitivities to others and a whole range of things that we need desperately.

I applaud the degree to which you have not only energized yourself and your communities, but you have been pulling together and influencing people like the Commission to come up to speed. I am going to send you questions in a letter. They will be made out appropriately for your background, but I want to read the questions I am going to ask just so you are thinking about them. Is Centers for Disease Control the appropriate, from your vantage point, federal agency to be conducting education programs on AIDS. Do they consult with minority groups adequately, and if not, can you make some recommendations specifically of how you would plan it better along the lines of our earlier discussion?

Two, how are CBO's utilizing the Centers for Disease Control National Clearinghouse? To what degree is it duplicating your services if at all? Could it function in such a way that it removes some of the burdens you are currently having to carry? And then lastly, the rather nuts and bolts thing, what is the total annual dollar value of each of your programs? How many people do you serve and how many federal dollars do you receive for your program, if any, for education, prevention, care and, also, what are the state fund contributions, if any? Obviously I am trying to round out where you stand right now, who you serve, about what it costs and who contributes to it. I think it will give us a fairly broad data base from just looking at you as an example.

So, those will be questions coming to you. I am not trying to lead you into any answers, but they have come to mind during the session here, and this is a special panel, and it has been very information, very helpful to us, and we know the tremendous work you are doing. We have seen you in the field. We have seen you working, what you are doing, your sensitivity and compassion on this whole epidemic and applaud what you are doing. Thanks very much for coming today, and we will be communicating with all of you as time goes on.

MR. MALDONADO: Could I say one thing? Early on when I spoke about the posters I used the word "models," and I just want to clarify that I was not implying that these were professional models but rather local community people.

CHAIRMAN WATKINS: Thank you very much.

CHAIRMAN WATKINS: The next panel, the last panel, is on the role of media in educating the public. On the panel is

Carolyn M. Wean, Vice President and General Manager, KPIX Television; Marcy Kelly, Chair, Entertainment Industry Task Force on AIDS; Dr. Armond Brodeur, President, National Association of Physician Broadcasters and Dr. Lawrence Wallack, Associate Professor, School of Public Health, University of California at Berkeley.

Welcome, members of the media panel today and we would like to start the first statement with Carolyn Wean.

MS. WEAN: First of all, I am very grateful to be able to be here and share with you my thoughts about what television can do and what we specifically have been doing. In deference to some of my colleagues here, particularly from radio, I will say that television is, while some of us might say the most important communication source, one of the most important communication sources for getting out frank and direct information.

I think if we thought back in time to an earlier era and one not so long ago, when diseases like tuberculosis and leprosy terrified millions, killed thousands and we could ask ourselves could lives have been saved if we had a vehicle and an integrated way of getting out information to dispel rumors, to get rid of misinformation and to create a compassionate atmosphere in which to address the problem. I firmly believe that television can help in that regard and I am also going to ask you for some things that you can do for us to help us do this job.

We really do have an opportunity to decide whether this can be done. There is a model in San Francisco. It involves WPIX Television, a Group W station and in 1983, almost four years ago, they made a major commitment to covering AIDS in many, many different ways and this was even before the death of Rock Hudson, which I think brought AIDS truly to the national conscience.

They made a commitment, which is quite significant. It may seem small. They assigned one reporter to cover this story, this epidemic, full time and in a television news room, with everything that goes on, making that kind of decision was quite extraordinary.

The other thing that was done was that we worked with community organizations. We got advice. We consulted with people so that when we produced stories, documentaries, over a hundred public service announcements, we felt sure that the information that was being transmitted suited the needs of the audience and was credible and was accurate.

We were among the first, on television that is, to run programs about how is AIDS transmitted; very specific, very

frank, I think sensitive and tasteful, and what we found from our audience was that this is exactly what they wanted. They wanted frank and direct information. Talked about how AIDS can be prevented and what resources are available and how can we make through volunteerism it easier for AIDS victims to remain at home, to make it less costly to the individual and to society to care for AIDS victims.

In just over four years we produced a thousand news reports; quite an achievement. While the AIDS crisis has abated -- I shouldn't say it quite that way -- certainly the rate of infection has slowed down in San Francisco and I think in large part the result of many massive education campaigns -- we felt that there was much more that needed to be done. In October of last year, Group W, our parent organization, agreed to work with the World Health Organization to expand what was being done at KPIX, to create a campaign that could be distributed nationally across the country, so that any television market would have the materials, our programs, available.

We are producing documentaries, a weekly news update, public service announcements, again, geared to special audiences and even home videos, which parent can use, if they feel the need or need help to talk to their children about AIDS and ways to educate them.

What is unique is that while this is national in scope. We allow the local station to take those materials and adapt them for their local audience because I think that is what local health television can do. It can address the 230 million people in this country, but it can address them in a way that suits the needs, the values, the life styles of the individual community.

So, we have produced a great array of material. Some work in San Francisco; others probably work better in some smaller towns and cities. The project is underwritten by Metropolitan Life. We hope to reach at least a hundred cities by the end of the year, making this the largest ongoing effort in television and we have had great response so far. We now have potentially almost 50 percent of the country signed up to carry the program. And, again, they can tailor the materials for their own specific needs.

We normally charge a license fee for efforts like this. One, because I believe if people pay for it, they will use it and they will promote it and it will get on the air. We are waiving that license fee so that the money can be donated by the local station that they would have paid to their own local organization.

So, what we are really suggesting is a partnership with grass roots organizations. I will give you two examples of

that which we have had success with in San Francisco. We have worked closely with AMFAR and the San Francisco AIDS Foundation. The San Francisco AIDS Foundation helped us produce a brochure of direct information. We have distributed over half a million.

Currently, we have been approached by Catholic Television to take our materials, our tapes, our programs and to use them in their own way, to edit them so that they can distribute them or broadcast them in their parishes and through their local school systems. So, although we are doing all of this, there is still a great deal more to be done and, like many Americans, I think it is easy for broadcasters to become complacent. We hear things like hasn't enough been done already. AIDS isn't a problem in my community and this is the place where I ask you for some help in our own effort at KPIX, but for broadcasters in general.

I really believe we can be helped in three ways. First, to dispel rumors and misinformation, we need to have the most accurate, current, up-to-date information available. We suggest that you give consideration for creating a regular, perhaps a weekly newsletter or wire service report in which authorities would make sure that the most current information is up there, be it information on new treatments or possible treatments or good programs that are being carried out in the various local communities. I really believe I can assure you that broadcasters would use that information, would get it out to the public and it is information that is desperately needed.

Secondly, I think we as broadcasters still need education, even those of us who have been working on this for some years and we suggest a national seminar, directed to broadcasters all across the country; newspapers, television, radio. They could be called together in San Francisco. You have the ability, I think, to amass the experts, to get the attention, to urge attendance. Such things as models for patient care, drug abuse treatment, media campaigns could be studied. I believe the San Francisco experience is valuable. For instance, the average cost of AIDS care from diagnosis to death is lower in San Francisco. The average length of a hospital stay is less and the rate of infection, as I said before, has declined; in large part, I believe, due to educational campaigns from so many institutions.

We would be glad to work with you -- "we" being Group W -- and bring whatever experience we can to help in coordinating this seminar, but, again, I think it is you who can bring together the authorities and the experts and pull the seminar together and make it a national one.

Finally, I really believe that one person can make a difference, particularly if that person is one who has the power

to unify and to inspire action and to communicate. So, I am asking, in conclusion, for the President to step forward to address the nation. He alone can do this specially, as a person who doesn't believe the myths and is a voice for the truth, as a supporter of massive drug treatment programs, as an encourager of volunteers, particularly for in-home patient care, as a supporter of research for drug treatments and AIDS treatment and as a lobbyist for those who have none, particularly the children with AIDS and particularly the children of IV drug users, who have AIDS. Then I really believe that for AIDS patients, the page in history that is now being written might have a different ending. I thank you.

CHAIRMAN WATKINS: Thank you very much, Ms. Wean.

Ms. Kelly.

MS. KELLY: Thank you. Mr. Chairman and distinguished Members of the Commission, thank you for the opportunity to speak today about AIDS and the entertainment industry. The media is recognized as a major force in our society, influencing attitudes and behaviors on many health and social issues. When we look at the statistics on American viewing habits, it is easy to see why. Over 98 percent of American households own one or more television sets and on average keep it on for seven hours a day.

Every week, over 95 percent of Americans are reached by radio. Currently, about 50 million own a VCR. In a survey commissioned by the Television Information Office, local stations were rated at the top of the most trusted institutions in our country ahead of churches, police and newspapers. It is obvious from this data that the media needs to be a vital part of any effort to educate the public about AIDS and of prevention.

The first network entertainment show to deal with AIDS was "An Early Frost," produced and aired by NBC in 1985. Since that time, networks, local and cable stations have begun to air a variety of news, information, dramatic and comedy shows on the subject. Public service announcements have appeared in local and network stations and recently motion pictures have included scenes and references to safer sex practices. The record industry has also become involved in AIDS education.

Warner Brothers Records is now developing a public service campaign on AIDS specifically targeted to adolescent and minority populations. These PSAs will feature major rock stars and will be aired on MTV and Black Entertainment Television, as well as radio stations nationwide.

In August of 1987, the Entertainment Industry Task Force on AIDS, which I chair, was formed specifically to look at

how the media might help in the current public health effort on AIDS. Twenty-four organizations are represented on the task force, including all of the television networks, the Academy of Television Arts and Sciences, the Directors Guild of America, the Caucus for Producers, Writers and Directors, Women in Film and the Producers Guild of America.

The Task Force will be distributing shortly throughout the motion picture, television and music industries recommendations on the depiction of AIDS and AIDS-related issues. Specifically, the task force is asking the creative community to: recognize that characters in the media with AIDS should not be depicted only as males, homosexuals, intravenous drug users or whites; emphasize that there is no evidence that AIDS is transmitted through casual contact; depict casual sex only if it is important to the story; indicate consequences of unprotected sex; include discussion of safer sex and condom use in appropriate scenes; indicate consequences of shared needles in scenes involving IV drug use, tatooing and ear piercing.

The Task Force is also part of a major conference for the Hollywood creative community on the media and the depiction of AIDS, which will take place on May 21, in Los Angeles. Underwritten by the Center for Population Options, the American Foundation for AIDS Research and AIDS Project: Los Angeles, the conference will include sessions on AIDS and sexual behavior, IV drug use, teens and babies.

Admiral James Watkins, Chair of this Commission, has been invited to present the keynote address at the conference. It is anticipated that this symposium will provide an opportunity for writers, producers and executives in the entertainment, an opportunity to learn not only important facts about AIDS, its transmission and treatment, but how experts on AIDS feel the media can help in preventing the spread of this disease.

In summary, I would like to say that I think that there is a very strong awareness of AIDS in the entertainment community, a desire to be sensitive to the issue and to promote, when applicable, positive AIDS prevention behaviors, such as the use of condoms and clean needles. Casual sex probably won't disappear from the screen, but as long as AIDS remains a public health crisis, there will be a stronger focus on the consequences of such actions and on taking responsibility for one's self and one's partner.

It would be most helpful if the Federal Government in its public education activities would include special efforts to work with the entertainment industry. Music, television programming and motion pictures provide a tremendous resource and should not be ignored in information campaigns. Thank you.

CHAIRMAN WATKINS: Thank you, Ms. Kelly.

Dr. Brodeur.

DR. BRODEUR:: Admiral Watkins, distinguished panel and colleagues, I am a doctor of medicine and I am Professor of Radiology and Pediatrics and Juvenile Law in St. Louis. I am Radiology Director Emeritus and Associate Vice President of the Board of Governors at Cardinal Glennon Children's Hospital in St. Louis, Missouri. For the past eight years, I have been actively involved in medical broadcasting, radio and television, but primarily as a health spokesperson and talk show host for radio station KMOX, an A.M., CBS-owned and operated station in St. Louis, which boasts one of the country's largest radio market shares.

For the past five years, I am privileged to have been faculty for the annual Networking Workshop of the American Medical Association, which is a seminar designed to teach physicians "how to" on radio, television and print media.

I am the first President of the National Association of Physician Broadcasters. We are pretty fledgling; we are 70 members strong. We are broad conglomerate of electronic communicators. We became incorporated only about two years ago and we had our first formal meeting less than a year ago. We are not limited to physicians, but it was the health communicator commonality that we physician broadcasters shared that led us to formalize our relationship.

Our most distinguished members include Surgeon General Koop, Dr. Art Ulene of the "Today Show" and Teresa Crenshaw of this Commission. We area group of broadcasters who learned their skills by doing rather than by didactic accreditation and it is my honor to represent that organization today.

AIDS awareness is our target goal for 1988. Interestingly, when I polled some of my colleagues recently, we found that broadcasting AIDS information isn't going on very well anymore, partly because everybody else is doing it, I am told, and partly because AIDS is fast becoming non-news, as news directors see it from their viewpoint.

The single most important message that we physicians can transmit to our media patients is responsibility for their own behavior, responsibility at any age. We should be able to convince them that AIDS is virtually, not exactly, but virtually a 100 percent preventable disease. We don't have all of the answers. For example, we asked ourselves what shall we do with that relatively recent report from The British Medical Journal, which asserts that the free AIDS virus is more plentiful in the saliva of infected persons than their genital secretions. The

obvious implication, therefore, is that AIDS is more likely transmitted from person to person during open mouth kissing than in sexual intercourse.

Now, we physicians have high credibility and we are talking about a disease that kills its victims a hundred times out of a hundred and I am hoping that the media representatives here and elsewhere will help us to decide, for example, what we really should say about open mouth kissing. Is it better that we caution rather than to assume that it is automatically safe. Obviously, the responsibility on all of us is very great.

I am hoping to have a uniquely personal window into the pediatric part of this epidemic, my specialty, if Cardinal Glennon Children's Hospital is successful in its quest for an ambitious, multidisciplinary AIDS care center now under consideration. It would be a great opportunity for me to network the best and the latest to all of my colleagues.

I will close by urging this distinguished Commission, possibly through the President, to bring together the advertising resources to be donated by this country's major corporations; weld them into a single unified nationwide campaign of AIDS education, targeted to each age group. They, better than anyone else, have the financial resources and the logistical skills to market the information in a manner so palatable that it would be absorbed and acted upon. What better than cartoons and cereal boxes for the children? What is more effective than rock music and teen magazines for the adolescent?

What better than the standard fare of daily soaps, sitcoms, skillfully contrives PSAs and public television programs to educate the adult? I feel that the major corporations must become partners in this massive network of information dissemination. Only they are capable of the logistics of selling anything to anybody.

I pledge the support of the National Association of Physician Broadcasters to cooperate in whatever manner is necessary to assure the accuracy of these messages and the time for action is now. You may refer to my written testimony for elaboration on my views concerning message effectiveness and I thank all of you here for the great privilege of having been allowed this moment with you.

CHAIRMAN WATKINS: Thank you, Dr. Brodeur.

Dr. Wallack.

DR. WALLACK: Thank you. I am pleased to be here today and I thank you for the opportunity. A recent New York Times headline declared that "Survey Finds Wide AIDS Ignorance."

Too many people believe that AIDS can be transmitted casually. Too many people believe that people with AIDS got what they deserved. Too many people believe too many untrue things about AIDS. Ignorance about AIDS is the public health equivalent of a loaded gun pointed at the heart of our society. I mean, ignorance not only among the general citizenry, but also among key policymakers, where it can't be tolerated. What I want to do today is just mention a few points to help us develop some realistic expectations about what the mass media can do in this terrible epidemic that we are facing.

First of all, it is important to remember that information does not equal education. Both are necessary, but not sufficient to change behaviors. Because the behaviors we are dealing with are very complex, intensive skill development is necessary. Also, competing messages in the environment run counter to the kinds of positive messages we are trying to get across. For example, we have a large advertising industry, which in great part is based on sexual exploitation as a way of getting people's attention and selling products. Well, AIDS messages in that environment certainly aren't going to be as effective as when they are presented in a more responsible environment. If we are serious about AIDS in the society and doing something about it, we have to be serious about advertising. We have to be serious about social change.

Second, mass media alone will not be able to change complex behaviors. Messages must be supported and reinforced by peer groups and by the larger community. It is in this community and peer groups where behavior change is going to take place. Media can play an important role, but when basic change occurs, it is not going to be on a grand mass level; it is going to be at the local level.

Third, the content of programs and materials must be a matter of fact, not of politics or advertising values. This is key to effectively addressing the AIDS epidemic and getting people basic information that is true.

Fourth, what can media do? Well, in general, media can cultivate an environment of understanding and positive attitudes that support AIDS policies and programs. How can they do this? The media has a well-known agenda setting function. Media may not tell us what to <u>think</u> but it certainly tells us what to <u>think about</u>. Media can keep us focused on AIDS issues so that we don't lose sight of what needs to be done.

A second function that media serves is to stimulate public discussion. The more public discussion on the issue of AIDS, the greater legitimacy the topic has and the more likely people are to enter into this public discussion. People will be

less reticent to talk about many of these issues that have been stigmatized over the years.

Third, media can be very effective in localizing and personalizing the problem to help reduce stigma. It can make AIDS real on a very personal level in communities all across the country. This means local media using local people as a way of humanizing the issues assosciated with AIDS.

Another role that media plays is to stimulate intermediate behavior change. Media can be very effective in getting people to call a hotline number and getting people to call toll free numbers, getting people to go out and get more information. In other words, media may not be able to present very complex information but it can take motivated people and direct them to where that complex information obtained.

A key issue, perhaps most important, is that media outlets need to plan with local community-based organizations that are dealing with AIDS issues. The battle on AIDS ultimately is going to be a local level battle and there is an enormous amount of expertise in communities. Media professionals and community organizations have to develop mechanisms for working together in a more effective way. New resources will have to be created to facilitate this process.

Finally, I just want to offer a warning about looking perhaps unrealistically to the media to do too much with AIDS. First of all, we tend to develop a fascination with media. We think that if just something gets on television, if just something gets in the newspaper, then somehow it means that we as a society are taking care of it. We can't be misled into this. We can't think that just because we get some media attention, even continuing media attention, that it is a solution or that this is sufficient. We need all the media help we can get, but we need it in addition to, rather than instead of other kinds of more complicated and controversial approches.

Also, media -- and I am talking about entertainment programming here, and news, as well, to some extent -- tends to focus on short term or partial solutions. For example, up to this date, one would think that condoms were the solution to the AIDS problem in the United States, that more methadone maintenance slots were the solution to drug abuse and, hence, the solution to AIDS among IV drug users. This is only part of the problem. You have heard a lot today about social factors and social issues, but, again, the tendency of media is to focus on very clear concise black and white aspects of issues. The media are not very good, by and large, on gray issues. We tend to get a misled about what some of the solutions are.

A third factor is that, in general, media, do not do a very good job of dealing with controversy or deal with

controversy in a way that ends up washing it out. By and large, I believe that mass media avoids controversy. AIDS is inherently a controversial subject dealing with almost everything volatile in our society and controversy has to be part of it.

The media also tend to use up issues very quickly. We have seen this to some extent with drug abuse and I worry we will see it with AIDS. People get saturated with an issue. Every series has their AIDS show for the year or their drug abuse show for the year and, again, it gives us a feeling of satisfaction and we move on. We have to watch the delicate balance between saturating the public with AIDS messages and really developing long term educational programs that are well-planned and coordinated with the other different levels of educational program delivery.

A final and very important point is that the mass media, for the most part, do not address minorities and minority issues. Unless we do that, we are putting various groups in our population even deeper into a hole that they are already in, that there is not going to be any coming out from.

Finally, I think media can do a lot. I think they have done a lot. I think the AIDS Lifeline show on KPIX is perhaps a milestone in mass media communication on a major public health issue and I think it presents a good role model for other stations. I hope that other places, other cities, other towns around the country will be as responsive to this issue as some of the media outlets who have already been involved. Thank you.

CHAIRMAN WATKINS: Thank you very much, Dr. Wallack.

We will start on the right this time. Dr. Walsh, you are up to bat.

DR. WALSH: I was very pleased with this particular panel because, after literally weeks of hearings, we have finally had the private sector rear its wonderful head. We have heard so much over the past several weeks of everyone turning to the Federal Government to supply all of the answers and you have been very refreshing this afternoon.

Your encouraging of the corporate sector to move forward, which they need to do -- now, I think that in California, you have certainly had more initiative from the corporate sector than has been true over the country as a whole. I know my own experience with them in the work that I do, there has been a great reluctance to identify with this epidemic, for reasons that I find hard to fathom. But, nevertheless, they are very reluctant to do it. The fact that you feel that they are on

the move, I think, is very encouraging to me. As a panel, you seem to feel that way.

I was impressed by the realism, Dr. Wallack, that you expressed, that the media can't do everything and that saturation, when you get it to do something, is a danger. Again, I go back to the United Kingdom, as I referred to them this morning. They did an AIDS saturation on the media for a week Christmas a year ago and absolutely turned off the entire country. The job was done; the country was not interested. They didn't want to see it anymore. They were AIDS' out, as far as the media were concerned.

Some of the questions that you raise are interesting to me and I will give you all the questions and then anybody can answer. You talked about in California, for example, explicit, fairly explicit, advertising and so on. Yet, we have found certainly resistance from the networks on explicit or too explicit advertising. I think -- when I say "advertising," I am talking of portrayal -- I hope that you will be able to sell your theme perhaps to a larger group of the broadcasting industry. Yet, it was explicit and too explicit advertising that killed the thing in Great Britain. So, there is a fine line to which you referred.

Secondly, with the national physicians network, Dr. Brodeur, one thing that has been apparent to all of us on this Commission and to those of us who are in the field of medicine, is that our own profession is among the most ignorant when it comes to this disease. I am talking as a whole. And we know the AMA has made every effort. Certainly, in Roy Schwartz, they have got, I think, one of the really great minds in trying to get this before the public and before the physicians.

Is the national physicians network doing anything in the way of education of physicians by automobile tapes for their cars or anything. I am not going to repeat what I said this morning, except that in speaking in New York last night to many physicians, I found an appalling ignorance of not only disease but of rules and regulations governing the disease and I wonder whether you are going to be attempting to do anything because the physicians themselves are very important.

No corporation, for example, will adopt a significant program if their in-house physicians don't encourage them to do it. And if their in-house physicians in AIDS remain as ignorant as they do or as they seem to be about this disease, we are going to have a great difficulty in using that resource and I would welcome your comments on that.

I think on Dr. Wallack's thoughts about the industry, I don't think the industry has ignored the minorities, as much

perhaps as you do. From what I see at least on television and I don't watch it seven hours a day, I am afraid, but I think what they have done is they have not been realistic about the way in which minorities are portrayed or treated and if that is what you meant, I agree with you, but I wonder, because of the sensitivity of that, whether anything can be done about it without running the risk of labeling AIDS a minority disease, because we don't want it to be a gay disease; we don't want it to be a minority disease. It is everybody's disease, as we have said repeatedly at these hearings and it is going to be with us for a long, long time.

So, there are a group of questions upon which I would welcome your comments. Anybody.

DR. BRODEUR: Well, Dr. Walsh, I will begin by answering what I can about the education of physicians. The National Association of Physician Broadcasters, as I said, is an independent group of doctors, who found each other because we were all doing the same kind of thing and in that group, interestingly, you will find some of the physicians who are the best educated about AIDS of any, but they do not wag the AMA. The AMA wags them, among other things.

For about 30 years, and I won't digress more than 10 seconds, I have been very much involved in the area of child abuse as a pediatric physician. After 30 years, I am ashamed to say that there is still an appalling lack of conceptual information by doctors. What do they do in St. Louis if they get a difficult case? They send it to my institution and let us report it. And from what I heard this afternoon, some of the AIDS physicians, it seems to me -- some of the physicians are doing the same thing about AIDS.

We will be very happy as a group or individually to go wherever or for whomever if someone will invite us to go to speak at their fora regarding the AIDS issue. I can tell you that we try as a group of broadcasters -- and we don't have a national office and a set of files and an executive secretary. We just are who we are. We would be very delighted to keep their hands over the fire with regard to AIDS and we do that, I think, in our individual programs, but so far as having access to all of the doctors in the United States, we simply don't have access.

DR. WALSH: Who prepares those tapes, you know, that doctors put in their cars, in their cassettes? Is that done by the AMA?

DR. BRODEUR: That is done by the AMA. There are some individual private corporations, as you know, that sell --

DR. WALSH: Oh, yes.

DR. BRODEUR: -- the review of the journals, but the AMA puts together those and we have, incidentally, those kinds of tapes in all of our medical societies. You can dial a certain number and get a free message about anything, but that is done by the AMA.

DR. WALLACK: I wanted to address your question about minorities in the flock in Great Britain. I think as we have heard today, and I have been here most of the day and I have been enormously impressed with what I have heard, is that a lot of organizing needs to go on. We have heard some of the black representatives say that the black leadership in America wasn't really interested in AIDS or at least interested to the extent that they need to be. So, I think a lot of organizing needs to go on, where people are brought into this and, again, feel some sort of ownership of the problem. Feeling ownership of the problem doesn't mean that you have got it and it is your problem. It means being involved in planning and doing something about the problem.

Now, in the U.S., I think we have a problem with many of the programs and policies that get developed because populations get planned for rather than planned with. If more effort went into organizing, especially with minority populations (and minority populations who often don't have the resources to do the organizing, like mainstream populations do),it would result in substantial progress. So you need to talk about some sort of capacity building. In terms of AIDS and minorities, I think if you had better planning, if you had better market research dealing with the populations, not based on how much money you have to spend and be attractive to advertising, but based on the interest of the local communities, you might see increased participation, increased understanding and you would see, I think, some of the stereotyping fall by the wayside.

MS. WEAN: To answer your question about network versus local television, as to which it should be or which would be the better for disseminating information, my answer is that both should be involved. I think that they can do different jobs, just as entertainment vehicles can do a different job than a public information campaign. The network by nature of having to reach across the coasts, the breadth of the country, I think, has to be more circumspect because they are talking to a larger, broader audience. And what local television can do is hone in on the particular issues that it faces in its community. Local TV stations understand those communities better and how to speak to them.

I manage a station in San Francisco. A few years ago I managed a station in Pittsburgh. The approach that might be taken in some of the programming or in some of the language would be very different for those two places. They are both in the United States. They both need information. Both marketplaces want information. All of our research has shown that but they want to hear it differently and, yet, they want accurate and fairly specific information.

DR. WALSH: Ms. Kelly, is a group like the NAB actually getting deeply involved in this situation?

MS. KELLY: I am sorry. I didn't --

DR. WALSH: National Association of Broadcasters.

MS. KELLY: I know the organization. They are not involved with the task force. We would welcome their involvement. The task force is --

DR. WALSH: Is there a reason for it or --

MS. KELLY: No, other than I believe that their primary office is here in Washington and the task force is active in Los Angeles where most of entertainment television is produced. We would be delighted if they would like to be represented on the task force. It is not a problem.

DR. WALSH: Thank you.

CHAIRMAN WATKINS: Dr. Crenshaw.

DR. CRENSHAW: Ms. Wean, I would like to tell you that your suggestion for a national conference for people in the media on AIDS I think is an excellent idea and should probably be more than a one time event. I think that in addition, if some dimensions of human sexuality are included, it might even be able to help some of the entertainment media to, without making their sexual episodes boring, perhaps introduce a little more depth and responsibility somewhere along the line. It is not always easy to do.

Your suggestion raised to mind perhaps the way that such a conference and Dr. Brodeur's organization could communicate. I know that as media people try to interpret medicaleze or even talk with physicians who haven't learned somehow to speak English in the way that can reach the general public, it is nice to have an interpreter.

One of the things I wanted to ask you, Dr. Brodeur, is the request was made about getting some press releases on a fairly regular basis from the responsible body that digested and

interpreted the information. With the 70 physicians that you have, in addition to Dr. Koop, would that be one of the functions that your organizations could provide?

DR. BRODEUR: I will apologize once more for the fact that we just were born and we don't have a treasury or a national secretary, as I said, so that we aren't doing all the things that we are capable of doing certainly or that we would like to do, but one of the things I have managed to do in the few months I have been president is to get a number of organizations to receive the mailing list of all of the doctors -- and I hope that you have been getting material from the American Academy of Pediatrics, for example, and some of the major groups -- Art Ulene and his Walk with your Doctor group. We have not gotten CDC yet in that mailing list group, but we will. M. D. Anderson Hospital is giving us cancer information and the answer is a resolute "yes." We would like to have a number of organizations that are concerned about health in any way sending us releases and I have asked them if they wouldn't mind, simply because -- even though we are, in a sense, medical writers, I suppose, we would welcome 30, 60, 90, 120 second material that we could scratch around and make it a lot easier for us. We would love to do it and I pledge that we will put it on the air for you.

DR. CRENSHAW: So, you could triage it, put it on the air and produce it if you had the resources to do that?

DR. BRODEUR: Yes.

DR. CRENSHAW: I think that you are being too modest about this little country organization. Perhaps you could share approximately how wide a population the 70 physicians reach across the nation, just to give some idea of the scope of the physicians, who are filtering all this data through the news.

DR. BRODEUR: Interesting that Charlie Fentress, a partner of mine, an associate in other matters, said to me today you had better be prepared to tell them just how many people you reach on a weekly basis and I said, Charlie, I have no idea, but it is literally millions. My own broadcast on KMOX radio, afternoon drive time, reaches approximately a quarter of a million people while they are driving home in any one segment of time. So, you extrapolate that across the 70 doctors in the country and the fact that some of their material is replayed that evening and so on, I would have to guess in the millions, but I just don't know where.

DR. CRENSHAW: So, if you were to receive material from other sources, it could be distributed widely --

DR. BRODEUR: Very much so, very, very much so because we go all the way from Dr. Bill Crounce in Seattle to Dr. Zenakis in Boston and Joe Fiori in Tampa and Bob Lanier in Dallas/Ft. Worth, myself in St. Louis, just to name five.

DR. CRENSHAW: Thank you.

CHAIRMAN WATKINS: Ms. Gebbie.

MS. GEBBIE: A couple of things. First, Dr. Brodeur, a comment and then a question. The comment is that I had some concern what we see happening with the media when something is presented as an example. You quoted a British medical journal study about saliva as an example and both had antenna that went up as to whether that was what we were going to see on the evening news. "Distinguished Physician Tells Presidential Commission All Previous Information About Transmission is Now Out the Window." There is such a difficulty with that process and I think we all have to look at that very closely.

That leads to my question. It is hard one. It is easy to get excited about a 70 member group that represents physicians on the air. Not all physicians I have heard on the air appear to use judgment about what they are putting on the air. So that the idea that press releases sent to your group would automatically yield good education in the community is not necessarily true.

What sense do you have about the level of continuing medical education and judgment that is portrayed in the kind of person who is a member of your society? I know that is a very difficult question to answer. But do you have some --

DR. BRODEUR: Can I come back tomorrow?

Well, actually, you know, people are people and everybody has a different DNA molecule going through his system, telling him what to do. You can always tell a doctor but you can't tell him very much. I must tell you that we don't have -- the NAPB is not a policymaking group to begin with. And, secondly, a number of the individuals in that organization are not only highly educated people but many now have had years of experience in the media.

One of the things that I wrote in my printed testimony before you was that we expected our physicians to be able to separate sensationalism from fact. When I mentioned the issue of saliva, I considered that for a very long time before I said anything. It has been out since sometime in late '87 and this is the first time I have mentioned it publicly.

The reason I mentioned it publicly is, quite frankly, I don't think -- and I am not an infectious disease specialist. I am a pediatric radiologist. That is an adult-type radiologist with the mind of a child. But I do know that you don't know and I don't think Dr. Crenshaw knows nor Dr. Bill Walsh knows for sure whether or not it is transmissible or contagious if there is an AIDS virus in the saliva, particularly if someone has just freshly their teeth, as they might well have and whether or not it is possible -- if you are talking about Influenza A, I am not as concerned, or mumps or measles or chicken pox or even tuberculosis, but we are talking about a disease that if you get it, the chances are it is a hundred percent.

So, my question is that, you see, if there is any doubt about the saliva, I think maybe it ought to be stated. Somebody ought to at least address it because we just don't know. We know that handshakes can't. I mean, that is pretty certain but I am not sure about what has been referred to as French kissing.

MS. GEBBIE: In fact, many people will say there is a difference between salivary contact, meaning if somebody's saliva droplet lands on your chin, from French kissing because there are differential degrees of exposure, not just to saliva but to the potential of -- your just having brushed teeth is an example, but, in fact, the point is you can't have that discussion in a three second bite. You have to have it for a longer time.

DR. WALSH: I do think it is important to point out that despite many attempts to positively identify transmission by saliva, that with all the thousands of cases throughout the world, there has never been a single case certified or demonstrated to have been transmitted by saliva and I think it is important to point that out.

Medicine is an inexact science. You and I both know that. We can never make a statement of never, you know, but there has never been reported.

CHAIRMAN WATKINS: I think that is a very valid point. It comes up constantly and is one I continue to make because I believe that from that piece of negative information, we will also have scientific data. It is not only in that area, mosquitoes -- we had a question on bedbugs. I think it is extremely important that we say, we have hundreds of thousands of cases in the world -- the World Health Organization has over 130 nations. They have a tremendous AIDS task force, with Dr. Jonathan Mann. Nowhere are we getting that kind of data that HIV is transmitted other than how we say it is. I think that becomes very important to say.

I think that perhaps as a scientist and on probability theory and one thing and another, you can probably postulate a situation where somehow under some remote conditions -- but the fact that we haven't seen it yet and haven't documented it seems to me to need be said more.

These are the kinds of things that I think become very important. We had this expose in the paper about early identification of neurological damage. By the time that gets through the system before competent scientific authority can come before us and say, you know, we just don't have compelling evidence anywhere to actually prove that. We don't know how valid the data is or the Cosmopolitan Magazine article recently on not to worry, women; heterosexual transmission just can't happen to you.

So, immediately on Nightline, fortunately, they put it in the context, proper context, and the Cosmpolitan article was refuted. I think that the fanning of fires of the unknown in this way becomes as detrimental to the national education process as anything we do.

So, my message the other day to a group of people at the National Press Club was to make sure they are extremely responsible. I have to say that I think in this case I have never seen reporting in any of the media, electronic and otherwise, that has been more responsible than it has largely been in this epidemic. I think there is a concern by those that are close to it and the people I deal with and have had an opportunity to meet in the written media, for example, they are experts on AIDS. They are good at it. They know what is right and wrong and so they write well.

And I think the electronic media has been the same way. I think that concept is extremely beneficial for the country. So, I think it is the way we present things that becomes important. Are we really in the back of our minds trying to tell people that there should be fear. Or whether we can make decisions in a calm fashion. I think it is the way we say that becomes very critical. I chimed in on this because it has come up so many times and I am just delighted Dr. Walsh brought that approach up.

MS. KELLY: I just wanted to say that I think that one of the reasons that several of us have brought up the importance of direct communications with the entertainment media, and I would expand on that to the news media also, is because the entertainment industry has the potential to reach, to educate and to inform so many millions of people. If there are questions on these issues and you don't want writers developing their stories based on what they read in the newspaper that morning, then direct communication is vital. If there is a body, whether this

be it or the CDC or whomever, that has the consensus of data and if that body could be communicating directly to people who work in the entertainment industry, then you would be assured that they would be representing your point of view.

CHAIRMAN WATKINS: Would you recommend that this be a clearly articulated function of the CDC clearinghouse that is being developed now?

MS. KELLY: If that is the appropriate body.

CHAIRMAN WATKINS: Is that the right linkage for a central clearinghouse, so that people can begin to establish the scientific validity of this study that has come out of a small group of scientists here or perhaps the one in a foreign country. At least we need a cross check or the ability to put new theories or data in the proper context.

It just seems to me that that network, that exchange of data before a new study is put out publicly is needed. Without it, new data tends to float through the country like wildfire and if we can bring the scientists to bear at the right moment, it seems to me that second thought becomes extremely important, particularly at this point in the crisis. I think as time goes on and the educational process matures that it may be less significant.

We haven't educated the very front line of our educational authority in the health care providers themselves yet. So, it is a time, I think, for all of us that requires special caution and I applaud your support for proper linkages with the scientific authorities to at least cross check information before it gets fanned out nationwide.

DR. WALLACK: I have made two recommendations in my paper that I think relate to this issue. Again, if we are in this thing for the long haul and we have to be, we have to be talking about increasing resources and capacity building. The two points that I made in my paper, are (1) that training in media relations should be made available to all community-based organizations dealing with AIDS. These people represent an enormous resource and they don't serve as effective a resource as they could, given the information needs that are out there.

A second point was that training in the scientific, social and journalistic aspects of the AIDS epidemic, should be made available to reporters. And I think you need to develop regional workshops for electronic and print reporters, in different parts of the country. These workshops might be associated with schools of journalism, or Schools of Public Health, or with health departments, or perhaps with community-based organizations themselves.

Another thing I wanted to mention from a communication campaign point of view, this issue of fear arousal is very critical. We are dealing with a problem where we want there to be some anxiety in the population, but we don't want there to be too much anxiety in the population. We want people to think they are at risk but only if they are really at risk.

You have to worry about stories that raise fear on people's behalf and don't provide them with an outlet to do something about the fear. This is one of the basic tenets of fear arousal in communication--if you get somebody anxious about something, you have got to provide an outlet for action. You have got to give them a place to go. That is why the linkage with community-based organizations is so important. If people are concerned, if they can't get enough information from the media and the media probably can't give them enough information that is explicit and tailored to their needs, we have to direct them to other resources.

The other point I wanted to make -- and this also has to do with the whole notion of how fast and if and when it is spreading into the heterosexual population outside of IV drug users and where it is to date -- is that our society doesn't mobilized around prevention. Historically, it never has mobilized around prevention. It is a downstream, pulling people out of the river kind of society and we wait until the crisis is here. We don't look upstream and try and keep people from falling into the river.

So, if we are really concerned about prevention, we have to be investing in a lot of resources at this point in the epidemic that seem like they are not going to pay off for years and years. This requires a major value shift in American society: to start thinking and planning ahead, rather than reacting to these issues simply by providing more and better and more expensive health care once people are already sick.

MS. GEBBIE: I have a second question and that comment is a good background for it -- for Ms. Wean and Ms. Kelly. What has been outlined as a level of commitment and a level of interest -- maybe it is the hour of the day, but I am being the designated skeptic here about the question of whether that is sustainable longer than one season of television shows in which every prime time show does one show on AIDS and one show on drug abuse and then off we go and the advertisers never change the imagery that they put in the ads.

It seems to me we have heard over and over again that the message has got to be the same and it has to be coordinated. So, my question is can you give us some reasonably specific ideas of what the community as a whole or units within the community could do to sustain the media industry in this shift that we see

happening in the short term? What could we do to convert it into a real long term change?

MS. WEAN: It is sustainable. Our experience has shown that. The campaign has been going on for four years and we had to ask ourselves is it enough already. What we found out is that the audience didn't think that it was because of things that you all have brought up, the latest rumor makes it cycle again. No matter how many times you bring up the mosquito issue and you think you have answered it, it comes back a couple of months later.

It is a very difficult task to do, one, because of the uncertainty, the fear. It is sustainable if there is, a network, an integration between the organizations in the community and between a panel like this and the media. We have been able to sustain it because we have had the support, the time, the energy and even in some cases, the money behind it, from AIDS prevention organizations, such as AMFAR and San Francisco AIDS Foundation.

We could not have made up a brochure ourselves that gave out the specific information. We are not experts. They were able to do that for us. We were able to pay the printing and also then we have the outlet to say this is available. Write in. Go get it. And then they could address some other communities that maybe we can't reach, particularly through public service announcements and news, the IV drug user. That is a very difficult community to reach and we are working to try to discover some things like that.

So, I think that if you get the cooperation, it is sustainable because we can produce the programs. We can produce the brochures. What we can't do is keep up with the information alone. That is why we have been able to sustain it for four years and now have made a nationwide commitment for a year because we have these organizations working with us. We have sponsors who signed up recently, advertisers, but some who have been with us from the beginning, such as Chevron of San Francisco, so that we aren't bearing the total cost of it; be it in people time or in money, we are being supported.

MS. KELLY: I agree -- Dr. Walsh, you brought up the point of saturation. I agree that is a potential problem and I think it is one that everyone who works in public information has to be very sensitive to. I would hope that all of the agencies within the Federal Government that are developing public information campaigns are coordinating with one another.

There are an enormous number of public service announcements being produced at this point on the national and the local level. I have great concern that they are all being

done at the same time and being thrown at the stations at the same time and, as someone on an earlier panel said, an individual, a public affairs person, has to decide which one they are going to put on.

I think one way to sustain it and to eliminate the saturation is for there to be a very strong coordinating body, if you will, or individual.

In terms of shows -- Larry brought up the disease of the week kind of show; you know, everyone does their drug abuse show, their alcohol show, their AIDS show, whatever, and that is a reality and it is problem.

I think, however, in dealing with AIDS that there are many ways to deal with it without doing a, quote, unquote, AIDS show. I think that writers, producers are becoming more concerned, for example, about how much casual sex is on television. Without even introducing the word "AIDS," one can introduce the use of condoms.

I think, as I said in my testimony that we will probably be seeing more marriages. I think there are ways of incorporating what you want without every show dealing with AIDS. The reality of it is there are a finite number of programs that only produce so many shows a season and you are only going to get so many of these anyway. I hope I have answered your question.

MS. GEBBIE: At least partially. If you think about or if your group meets and talks about it, you could send us back some comments on what is it we can tell community-based organizations to do to be helpful to you or what it is that state health agencies or hospital groups or the physician broadcasters or the CDC could do that would give you the back-up to keep moving. I am truly more interested in those image shifts than in the show of the month effect.

MS. KELLY: Well, let me just say that I think part of it goes back to what we keep saying, is the linkage. Your ability to sustain is directly related to your ability to feed information that is new and is interesting. I also invite the Commission to provide whatever information you like at the May 21 conference that we are doing in Los Angeles, that is specifically targeted to writers, producers and people who create entertainment programming. We are still in the formative stage of that conference. If there are specific issues that you feel that you would like to bring to that public, I am delighted to assist you in doing that.

MS. WEAN: I can give you two specific examples of how information can be distributed to the media. One is locally, the San Francisco AIDS Foundation -- I am sure there are other

groups in other communities -- puts out a media alert with information, updated information that has proven to be very useful. They also are very available to us.

It is not an official media hotline but I am sure they feel it as such. And during October, during AIDS awareness, the CDC mailing of information and events and so forth was very helpful. I think on a consistent basis that does need to happen.

CHAIRMAN WATKINS: Is that continued, Ms. Wean, that mailing you talked about?

MS. WEAN: The San Francisco AIDS Foundation, yes. I don't think the CDC has continued. I am not sure about that.

CHAIRMAN WATKINS: Do you have an idea of what an information flow or exchange might be from your vantage point? Here we had today Gil Gerald of the National AIDS Network, coordinating with 300 different entities nationwide. We have so many national groups now; the AIDS Action Council itself is into 50 states with all the variety of organizations and there are certain networking potential there for the right contact points. We obviously need work from national authority that can get into the latest front edge of technology and answer some questions, much as I brought up with the limited reports of early neurological damage being so widely publicized and not into context.

What are you missing? What are the voids in the information flow that you would like to see hardened up a little bit, just flowing to you, not directing, but just giving you information? Do you have some ideas of how that might be enhanced? Let's take federal and then state, maybe from public health standpoint, if that isn't in your linkage now, and something that might be conceptually useful for us to recommend, a much more aggressive action to pull that together.

MS. WEAN: I would like to give that some more thought and give it to you in writing if I could.

CHAIRMAN WATKINS: Would you do that? That would be very helpful.

MS. WEAN: But I think the CDC model in October is a beginning place that I would book and use that example as a starting point.

DR. LEE: Am I on?

CHAIRMAN WATKINS: You are on.

DR. LEE: I saw the lights and the camera and realized that the beautiful people were here. When we first outlined our work, the media and what they could do for us was listed very, prominently under our education section. I think that we are late in getting to it. As any presidential candidate knows, 30 seconds on prime TV is worth 14 weeks on the campaign trail.

If we want to sell our message or a message, that has to be one of the things that we look at. Now, we have proposed among ourselves having a media and PR type of advisory council. The Admiral, our chairman, is somewhat reticent, unlike most of the rest of his Commission members, and he feels that he wants to stay away from that, but maybe we can get him to change his mind.

I would ask you what is the best way to interface with your industry because it would do us a lot of good. It would do the cause a lot of good. It would do all these people on the panels before us a terrific amount of good and I think we are a little bit unsure about the mechanism.

MS. WEAN: I would suggest that there probably are several ways, in effect. I think certainly the kind of task force that has been described here, would be useful. I think it would be very useful to have -- and this is from a local television and a news-gathering point of view -- some hotline or some designated authority who would be available on both a national and a local level, to answer questions, to dispel the current rumor once again and give us the precise information.

DR. LEE: That would be terrific. You know, if we could -- you know how we started off?

MS. WEAN: Yes.

DR. LEE: Okay. If we could work with the media here, I think it would be a terrific plus myself.

MS. WEAN: And I do believe the task force and seminars, be it on a regional or on a national level, and urging by this panel for broadcasters to attend and from the executive office itself, could be very useful in getting those broadcasters, who have not yet signed up, so to speak.

CHAIRMAN WATKINS: There was a recent session in New York with several hundred people in your business coming together on this very issue, the one you just raised. I would call it a seminar. It lasted a couple of days with a lot of working groups and a tremendous amount of interest. I think it is the first one that I have seen.

I don't know how widely it was aired with all of you but I certainly think you are right on the mark on that and this is where a lot of linkages could be started and established and then made more permanent as you need those. If the President feels our strategy is in the right direction and wants to pick it up as his legacy and if he wants to pass that baton along to his successor, then we have the hope that there will be a sustained long range effort. We have got to get really serious about those longer term linkages that aren't going to go away as we talked with the community-based organization networks. They are going to have to be here to stay for quite awhile until we can get our arms around this epidemic.

So, we are looking at a whole new system in the country of talking about health. When we got the information on sexually transmitted disease increases yesterday, it is very worrisome to us that we tend to focus on one issue and we can't grasp the broader set of issues that are all intertwined in that. We are going to have to stay close to these for quite awhile. They are not simple to solve. We have set a ten year program just in one area. That kind of commitment to a sustained approach is necessary if for nothing else than to tell the little people working at grass roots that there is some help on the way and not to worry; it is not just a one-year budget cycle.

I think there has been a great fear out there for grass roots voluntarism and other people who want to help, that there will not be sustained support coming. I think the integration of the media into the education process in perhaps a unique way that hasn't been there before is very important. The national public radio people have done a tremendous job with this, along with the C-SPAN and CNN, covered a lot of these hearings and allowed the dialogue with the best witnesses in the nation taking place. And I can't tell you how many people are talking about the fact that they watched an entire set of hearings, which I think is impressive, that people have that kind of interest.

When UCLA opened up their AIDS course, a couple of thousand applied. They couldn't squeeze them into a 500 person auditorium. When I was in Louisville, they had to open the additional tiers up above in the theater and people had to come to hear about AIDS on a panel I was on with Randy Schultz and some other people. So, there are tremendous opportunities here right now to grasp this and to move it together in a collaborative way. So, I think your intense feeling about getting those linkages set up so that you feel comfortable that you are playing the game in a professional and competent way and you feel comfortable that what you are doing is in synchronization with the community-based organizations and the

other people that are really networking this and have the same drive and enthusiasm you all do, I think, is extremely important.

DR. LEE: Does Ms. Kelly have anything --

MS. KELLY: Well, I guess I would just like to add that within the media there is a very important distinction between the news and information and the entertainment or programming side. They have very specific and different needs. The people who work on weekly shows or daily news shows have their own time line and people who are creating programming for network television or cable television have other calendars.

So that if you should recommend or through your recommendations have developed an office to deal with it, it should be noted that there is a difference in the way you reach these two populations.

CHAIRMAN WATKINS: Anyone else have any further questions? We want to thank this panel very much. We have been waiting for this for some time to bring it to the Commission's attention and I think you have been wonderful witnesses. We thank you for staying this late hour with us and hope that we can continue the dialogue with you as time goes on. The door is open to us at any time for the exchange of views. I have asked for some additional information and always you can write and you will get up to the top of the priority list in response because you have been great witnesses.

Thanks very much and we will stand adjourned until tomorrow morning at 9 o'clock.

(Whereupon, at 6:07 p.m., the hearing was recessed, to be reconvened at 9:00 a.m., the following morning, Thursday, March 3, 1988.)