PRESIDENTIAL COMMISSIION ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC

HEARING ON PREVENTION AND EDUCATION

The Hearing was held at the
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Hearing Room B
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Thursday, March 3, 1988

COMMISSION MEMBERS PRESENT:

ADMIRAL JAMES D. WATKINS (Ret.), CHAIRMAN

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CORY SERVAAS, M.D.

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POLLY L. GAULT, EXECUTIVE DIRECTOR

COMMISSION MEMBER NOT ATTENDING:

JOHN CARDINAL O'CONNOR

I-N-D-E-X

I-N-D-E-X (continued)

P R O C E E D I N G S

MS. GAULT: Ladies and gentlemen, members of the President's Commission, distinguished guests, my name is Polly Gault. I am the designated federal official and in that capacity, it is my pleasure to declare this meeting open today. Mr. Chairman.

CHAIRMAN WATKINS: Good morning and welcome to our third in a series of hearings on education. Yesterday we began our examination of the various education strategies that can be utilized to stem the spread of the HIV infection. When we opened yesterday morning, I said that it is important that when we hear the word education, we do not associate it only within the context of a formal setting of a classroom. This point was stressed over and over again as witnesses came before us and told us how they are educating those hard-to-reach youth, most of whom are out of the mainstream. We also heard testimony regarding the educational efforts of community-based organizations and from representatives of the media who told us what they are doing today and what their more aggressive plans are for tomorrow.

Today, we are going to focus our attention on education of our nation's school children. These children do not pose the same degree of challenge as to some of our hard-to-reach youth. We know where they are. Nevertheless, the challenge to influence them is also real, for while giving them a message about the HIV epidemic is perhaps easy, giving them a message which they understand sufficiently to alter behavior is not such an easy task.

Today, we will hear the views of various educators about what type of information concerning this epidemic is appropriate to provide for our nation's school children and what is the best way to deliver it. I am now pleased to introduce our first witness today, Secretary of Education William J. Bennett. Secretary Bennett has served in his current position for three years. Prior to taking over the leadership of the Department of Education, he was the Chairman of the National Endowment for the Humanities. Secretary Bennett has been a leader and spokesman for better education in our nation. We are honored and delighted that he has joined us today to present his views regarding AIDS and education in our nation's schools.

Welcome Secretary Bennett and please let us have your statement.

SECRETARY BENNETT: Thank you, Mr. Chairman. As you know, Mr. Chairman, I visit a lot schools around the country, about 90 schools to date, and I often complain in those classrooms and buildings that I do not often enough see maps. I cannot complain this morning. You have got a map right there

above you, and that is good. This would be a good place for the next geography hearings that we hold.

I appreciate the opportunity to testify before you today regarding our efforts to educate young people about AIDS and to prevent the spread of the disease. My involvement in the AIDS issue stems from my responsibilities as Secretary of Education. From the beginning, all have agreed that education is a critical part of our effort against this disease. Much of what I have sought to do is to insist that the information and advice that young people receive about AIDS is medically and pedagogically sound. In presenting this advice, we have been acutely conscious of the fact that we must speak to young people in a manner that recognized their youth and the need to provide guidance appropriate to their age. So, in some respects, we speak to young people and adults differently.

I understand that at present, 32 states have mandated that information about AIDS be presented in their schools. Many schools and school districts are developing AIDS education programs and others already have them. You will be hearing, I take it, from other witnesses about this later on. To assist parents, educators and state and local officials in January of 1987, the Surgeon General and I issued a set of principles to guide AIDS education in the schools. And in response to numerous requests for more detailed information about AIDS education for young people, in October 1987, I released AIDS and The Education of Our Children, A Guide for Parents and Teachers.

In producing AIDS and The Education of Our Children, we relied on the best medical information available. We put that information in an appropriate instructional context, emphasizing that teaching our young people the time-honored lesson of responsibility and self-control is the best lesson we can teach, and the most reliable safeguard against contracting the AIDS virus.

Response to our booklet has been overwhelmingly favorable. At the Department of Education, we have never had another publication generate the kind of interest that this booklet has. Over two million copies of our book have been requested since its release just five months ago. This two million figure includes roughly 375,000 copies that have been requested in excess of our present supply. In fact, I now intend to devote most of my uncommitted discretionary funds to meet the demand for this book. Even so, we are still uncertain that we will be able to meet the public demand.

Parents, teachers, school principals, and superintendents tell us that what we have to say is sensible and useful and thousands of them have written the Department requesting additional copies. AIDS and the Education of Our Children has been distributed to family physicians around the

nation as a public service by the editors of the journal, Medical Aspects of Human Sexuality, and it is a recommended reference in the Center for Disease Control's "Guidelines for AIDS Education in the Schools," published in January of this year.

Nevertheless, there are still a few who have been critical of us. They have argued that we are merely moralizing. But, in fact, we have been doing something else. What we have presented is the teaching of moral realism and such a teaching is essential in this effort. Let me explain. We all know that values, the moral beliefs of young people, are a powerful determinate of their behavior. Thus, a 1987 National Academy of Sciences' report, Risking the Future, noted that young peoples' view of themselves, their self-perception, their sense of who they are, who they can be, who they want to be, is the single most powerful influence on their sexual behavior. That is why we seek to put AIDS education in a moral context, not just because as adults we have a general responsibility to be concerned with moral issues, but because moral beliefs and habits are key to behavior, and behavior is the key to protecting against AIDS and to curbing the spread of the AIDS virus.

I would note just parenthetically that there has been a lot of discussion, obviously a lot of it stimulated by the Commission, about treatment. In treatment as well, in successful treatment, as you know, Mr. Chairman, once again the whole issue of values and beliefs and aspirations is very important for a treatment to be successful. In many cases the individuals involved must commit themselves to a reordering of their priorities. So these things matter.

Behavior is the key to protecting against AIDS and to curbing the spread of the AIDS virus. We should not be afraid to talk about the demands of decency, of self-respect and personal responsibility in the presence of the young. Indeed, AIDS gives us one more reason, indeed I think an urgent reason, to meet this responsibility. If we refuse to speak in a morally realistic way of internal restraints on behavior, we are abandoning the single most effective means of influencing young peoples' behavior.

With regard to AIDS education for young people, I believe we are seeing encouraging signs of progress in facing up to this reality. Not too long ago, for example, condoms and safe sex were being hailed as the essential element of the AIDS education enterprise. Some rushed to embrace condoms as a kind of panacea. A few teachers even brought bananas to class to illustrate the "technology", as they called it. At the time I described this sort of faddishness as "condom-mania". I was glad to see the Surgeon General refer to condom-mania a couple of months after. I said that excessive reliance on condoms was a species of self-delusion. We knew then and we know now that for

all, but especially for young people, restraint and fidelity are the best means of guarding against AIDS, against other dangerous diseases and, of course, against other undesirable consequences. Of course, if we do teach about condoms, and many schools will decide to do just that, then we must be truthful in what we say. We must be truthful in what we say in regards to what we know about their reliability and their lack thereof.

Let me be clear. The differences that have emerged regarding AIDS education for the young are not simply trifling pedagogic ones. They are over basic philosophy. What is at issue is whether or not personal responsibility should be taught, expected of our children and used to our advantage in the fight against AIDS. Those who seek a prophylactic solution to AIDS are refusing to confront the more difficult, the more pressing, the more real issues -- the issues of conduct and personal responsibility, issues at the behavioral heart of the AIDS epidemic and at the heart of much of the controversy surrounding AIDS.

Whether with regard to condoms or clean needles, we must reject the fruitless quest for a prophylactic solution. This quest will fail. The search for a technologically fail-safe method that will negate the harmful consequences of some sort of human behavior will fail. "Find us a technology or a treatment program to insulate us from the consequences of our own acts," says this modern sensibility. "Find us a way to compensate for it, to protect against the consequences of all human behaviors," it says. "Find us a way to protect everyone from all his actions, whatever they may be. But in fact, you do not have, and I guess we will never have the technology that will make irrelevant the demands of individual responsibility.

The false promise of such a solution is particularly dangerous for teenagers. Teenagers are not notoriously prudent. Indeed, teenagers are risk takers and risk takers are less likely to alter their behavior when they hear an equivocal message. With respect to AIDS, teenagers and others will not heed the mixed message favored by some, namely, "go ahead, have sex, but be sure to used a latex condom supplemented with jelly or cream containing at least 65 milligrams of nonoxinal-9". Teenagers in the heat of passion are not very likely to follow this advice. Instead, I think our efforts must emphasize changing individual behavior and we will do this and we will succeed in this only if we reach young people during more tempered moments and offer them

good reasons to resist the temptations that are sure to arise in their lives.

Let me add a word about proposals for expenditures for drug treatment programs. As I said, this has been in the news a good bit. I certainly have no desire, as you know, Mr. Chairman,

to pinch pennies in fighting AIDS or drugs. It may well be that more money for drug treatment is needed and desirable. But we must also focus on improving the effectiveness of treatment and we must be wary of sending the message that more treatment, useful as that may be, is the major thing needed in the fight against AIDS. In the prevention of the spread of this disease, individual responsibility and prudent public health measures as well as treatment I believe are key. Individual responsibility can be fostered by sound government programs and policy, including testing, counselling programs that provide the necessary information for responsible behavior, drug treatment programs that provide aid in altering behavior, and laws that impose sanctions for irresponsible or dangerous behavior such as knowingly transmitting the AIDS virus. These policies, like our education efforts, must support and emphasize the necessity of individual responsibility for sound behavior. Without individual responsibility, we will be in the treatment business forever.

Your financial recommendations will triple or quadruple every year as your clientele increases ad infinitum. You will have more and more people at your doors unless we can get hold of this problem before they get addicted to drugs or involved in other problems. In preventing AIDS and in preventing illegal drug use by young people, we largely know what works. It is not a mystery but it requires that adults follow common sense when it comes to educating young people and protecting their lives. It requires sustained attention to raising the young with sound standards of behavior in addition to providing the facts about AIDS and drug use. In some cases, we adults must relearn these facts if we are to meet the responsibilities of protecting our children from AIDS and from the other pathologies that threaten their lives today. Thank you very much.

CHAIRMAN WATKINS: Thank you very much, Mr. Secretary. This morning I would like to start our questioning on the right with Dr. Primm.

MR. PRIMM: No questions.

CHAIRMAN WATKINS: Dr. Walsh?

DR. WALSH: Mr. Secretary, in part you are preaching to the choir, at least with this Commission when you talk about behavioral change and the necessity for it as well as stressing, as I think the Commission feels, in our ultimate and final report, that individual responsibility is really going to be the key to the success in the fight against AIDS. You have gone around the country a great deal, and you have some opportunity to follow up with the reception of your education brochure. We have heard a lot of testimony indicating positive hope and that there have been some outstanding examples of behavioral change.

I wondered if you would like to comment on the success of our programs to this time, as to whether we have seen behavioral change to a satisfactory extent in the high risk groups that we are now concerned with such as the minority population. Can we reach them through the schools with the background of the type of pamphlets you distributed or the type of communication that HHS is trying to send out?

SECRETARY BENNETT: Sure, Dr. Walsh, let me try to mention a couple of things.

We do not have conclusive evidence yet in the specific population we talked about. We have some evidence of certain things. Let me just briefly describe it. Take drug use for example. Among all teenagers it is generally down in most categories but it is not down in regard to crack. Crack use is level or up I believe. We do not, have the data to be able to disaggregate by population. I think most observers on the scene, would argue that among our inner city minority populations, young kids, teenagers, drug use is not down. Not only is the use of crack up I would guess, and I think it is an educated guess, that the use of other drugs would be up in certain populations as well. So that continues to pose a very great threat to our young people, not simply in terms of the possible transmission of the AIDS virus but for reasons of the dangers of crack in itself.

In other areas such as sexual activity in young people -- sexual activity among young women in our inner cities -- there is some evidence that there has been a decline in premature sexual activity, early sexual intercourse for young black females. This is obviously encouraging if this is true, and if it is the case, we want to find out the reasons for its effectiveness. The point I would make is that we should not treat altering the behavior of young people as an impossible task. We should not throw up our hands and say, as I have heard some people say, well, kids will be kids -- which, of course, is true, therefore let us just try to limit the danger of their acts and limit the consequences of their acts. It is much easier to alter the behavior of people when they are younger than when they are older. And, again, I have no argument against sound treatment programs, but a key to many successful treatment programs is to alter the behavior, the value system of a person. It is easier to do that with a young person before they get on drugs than with an older person whose habits are ingrained. A third group, I am not expert about, but have been reading a great deal about, is the homosexual populations. I think that there are a couple of reports that suggest there has been terrific educational effort and a dramatic change in behavior and I am confident that is true in certain areas and certain parts of the country and certain cities where these efforts have been undertaken and where they have been well received. I do not believe, however, based on what I read, that one could say that

this is the case everywhere. There was an article in the Washington Post in November, interviews with a number of heads of counselling clinics, saying that there are still a terrific amount, a tremendous amount of casual, anonymous sex going on without people who are engaging in it using condoms, taking precautions and so on, but I am confident there is not much hard data.

The overall point I would make, however, is that it is possible to influence young peoples' behavior. It is only in 1988 I suppose, that this would come as a shock to anybody. People have been doing this for 2,000, 3,000, 5,000 years, and we know what works. What works is to surround young people with adults who care for them, who are good examples to them, who give them sound precepts and encouragement in the right direction. The National Research Council report, Risking the Future, basically backs up Aristotle in saying that young people's sense of who they want to be, what they want to be, their aspirations, their telose as Aristotle would put it, has a lot to do with the kind of behavior they will engage in.

What can effect that behavior? Adults. What are the settings? Good schools. Good schools make a difference. Churches make a difference, churches and synagogues. Neighborhoods make a difference. The intervention of responsible adults, even if those institutions are not doing the job, a mentor, a Eugene Lang in New York, or other people, can make a very positive difference in peoples' lives. There is no mystery.

DR. WALSH: We have also heard suggestions about perhaps random testing or some such sort of thing at the college level. Do you have any particular attitude towards the problems of testing or the value of testing at adolescent, say high school or early college level? Or at any level? Or testing in general, from the standpoint of giving us any baseline?

I was disturbed by reading in our papers here in Washington of that high school in suburban Virginia that turned up with several youngsters that had tested seropositive between senior year or during senior year and freshman year in college, and again, you do not always believe what you read in the papers but the fact was that there was expression of some of the students that there was probably still significant casual sex and probably a significantly larger degree of positivity although there is no data to substantiate that at all. Do you have any attitude on that?

SECRETARY BENNETT: Yes. From the beginning, I have argued for a greater use of responsible testing, for routine testing, and I do not think, unlike what I would say in other areas, that I would draw a hard line of demarcation between

adolescents and adults here. A position I have held, and many other people hold as well is that we should have routine testing for people for admission to sexually transmitted disease clinics and hospitals and the like and if that person is a 15-year-old, I think we should treat that person the same way.

As members of this Commission know, we now estimate, that, one million to 1.5 million people are HIV positive and only 10 percent or 15 percent of those people know it. Knowledge should forever govern ignorance in all areas, in particular I would think in the practice of medicine and public policy, we need to know more. So I would not make an exception for adolescents there. There are some issues here where one wants to speak to the young people differently than one speaks to adults, but on the issue of testing, I think we probably have the same criteria for young people as for adults.

DR. WALSH: My final question, Mr. Secretary, would be along the lines of again, other discussions we have had or witnesses we have heard. Is the Department of Education contemplating any modification of that bulletin, AIDS and Children, which I thought was excellent and obviously it has had great receptivity. Is consideration being given to modifying it for minority populations? Because we have heard consistently from minority representatives that one of the reasons they are not being reached is that they have to be reached, in effect, in their own language and at their own level of literacy and that sort of thing. We have had other witnesses say that we have to be much more explicit with some of these groups because of the lack of educational background, and I wondered if you were contemplating doing anything that would be a variation perhaps on the very good thing?

SECRETARY BENNETT: There are several possibilities, Dr. Walsh. We are considering a Spanish language version of the book as one possibility. Second, we will continue to update the book and respond to any recommendations that are sensible in terms of change. When we look at the requests for the book, I do not think we can generalize from the mail we have received that this book is not being well received in the inner city community. It is, and we are getting requests for lots of copies. But, in general, remember that we have not received one cent from the Congress for our work on AIDS and education. We have been looked to for guidance and recommendations and people have said, what is the Secretary of Education going to do about this? They said that six months ago in any case, but have not given us any money to do anything with so we have been taking the money out of our discretionary funds.

The lead agency here, of course, is HHS, and CDC particularly has been given the major responsibility in the development of guidelines, educational guidelines with

Congressional funds. Now, we work very well with CDC. As I say, our book is on the CDC recommended list. My guess that is there is to be another major venture in this area, we will probably not receive the funds, CDC or HHS will, but we will be glad to help and offer advice. We are looking for some money for the book. We still have 375,000 to send out. We wrote Mr. Creedon about it. Maybe he has some money. Maybe he is considering my letter this morning.

CHAIRMAN WATKINS: Conflict of interest. Dr. SerVaas.

DR. SERVAAS: Thank you for your very excellent presentation. Secretary Bennett, when I was in medical school, we were taught that AA was the best group that we had for alcoholics to change their behavior and that it worked best, better than anything else we had, but it almost never worked unless there was a faith involved, and that interested me. We did a lot of work with key challenges of drug addiction. It is a group that has a 10 or 15 year track record, and when they look back - they go back 10 years - they find about 87 percent of the people are still off drugs. That group also has a religious component. My question is, have we ever done any studies where we have looked at children who have been in parochial or church or synagogue affiliated schools where moral issues are taken up versus the children in inner cities who have not had any such training?

Do these parochial school children end up having behavior patterns that are better than the children who are in secular schools and not exposed to spiritual values? It would seem to me that there would be enough inner city children who have been placed in religious schools so that we could make a fair comparison and my question also is do you believe that some TV programs are giving our youth the wrong signals about the importance of developing high standards of behavior?

SECRETARY BENNETT: I will ask John Walters, my special assistant to comment on the question about studies and then I will come back and comment.

MR. WALTERS: Generally speaking the studies of individual students have not focused on parochial school children versus public school children. There have been a couple of studies done on the religious convictions of students as it relates to their behavior, and generally speaking, children who have less trouble with the law, less problems with teenage suicide, teenage pregnancy, drug abuse, are students that have strong religious faith, greater involvement in extracurricular activities, greater involvement in school. Obviously, there is a connection between their lives being involved in healthy and productive things rather than being left idle and allowed to

wander, but there have not been specific studies, that I am aware of, measuring parochial versus public school children.

SECRETARY BENNETT: Obviously, religion or faith can be a helpful support to people's beliefs and even a ground or motivation for their actions. But we do not have any data, and we certainly would not want to suggest that proper instruction in a sense personal responsibility in the public schools, entirely within the first amendment, could not achieve the same effect. I believe that it can. But, of course, from time immemorial, the relationship of personal belief and personal action has been clear.

In terms of TV programs, I pretty much regard TV as a cultural wasteland anyway for the most part, and I do not look to TV for great efforts of reform either in terms of students' academic performance or in terms of teaching of a sound value system. Occasionally good things are on television, of course, everyone knows that. My main task as Secretary of Education has been to be to reform the institution which is supposed to educate people, which is school, rather than working on making television more like school, I would rather make school less like television because that is the institution that is supposed to be educating people. TV never came into being by saying we are going to educate people. There are a lot of hopes that TV would, but schools do exist to educate people and to guide people and they can do the job, but that is not to say that a lot of what is on TV is helping. It is not helping.

One of the reasons that you are interested in this for general purposes is that a lot of kids watch TV because they do not have anything else to do, and one of the reasons they do not have anything else to do is a lot of schools do not give out homework. So I believe in the marketplace of ideas and I believe that assignments in algebra should compete with "The Love Boat" or MTV.

DR. SERVAAS: Thank you.

CHAIRMAN WATKINS: Dr. Crenshaw?

DR. CRENSHAW: Something that is not very widely apparent in my opinion is that between the people who are liberal sexually and those who are conservative sexually, in relation to the AIDS issue, I think there is a great deal more common ground than is acknowledged. First of all, everybody has the same goal. We obviously do not want our teenagers to become infected and to get sick and to die, and in my experience as I have talked with individuals in the gay community, I have not heard one who is against monogamy. They just simply do not believe it is realistic for everyone. The same is true when I talk to people of a more conservative orientation because they have expressed to

me that if, in spite of all the advice and emphasis and effort to get someone not to have sex at all, they do not want the kids having sex without any protection and losing their lives if they are not going to follow the very best advice.

So what I think and what I wonder about is if there is not a way, since we are pulling in the same direction, even though the modus operandi is different for different groups, to achieve this common goal? I think it is a great advantage because in a lot of areas, there is not even a common goal to pull for. What can be done to improve the dialogue and the negotiation and the communication between the differing points of view to see if we cannot achieve even more cooperation so we really can be pulling in the same direction? I think until we achieve that in society, we fractionate the confusing messages. I think that the ultimate solution is in the dialogue between leaders in both camps. What do you think is possible, and what do you recommend?

SECRETARY BENNETT: I agree with you, Dr. Crenshaw, that there is a lot more agreement there than meets the eye. You know, one finds with this issue, as with other issues, some have a great interest in accentuating the differences between people rather than the very large areas of agreement. I noted with amusement, for months people saying that Dr. Koop and I were virtually in opposition on this issue, when in fact we were in virtual unanimity on the issues. I think what is required to keep the dialogue going is candor, for one, people being straightforward and honest. Second, sharing the information that we have, and third, recognizing that there is a good deal we know about what works and what is effective in the education of young people.

Quite apart from the AIDS debate, there are lots of reasons for encouraging young people to be, if you will, conservative, not politically, but sexually, when they are young. How many more teenage pregnancies do we need? How many more years of 400,000 abortions a year do we need? How many more wrecked lives in the inner city of female headed households do we need to make this case? Just bringing to light what is actually going on, the study done of the young women at the Brady Hospital in Atlanta, young, teenage black girls who were there, pregnant, and they were asked about the instruction they received, and they had had sex education courses. Nine out of ten of these girls said that no one ever made the case to them that they actually should not do it, that they should wait. No one had ever made that case to them.

Now, this does not shock me because, as I said, I go into the schools and I find 17-year-olds who have never been told why the United States is a freer country than Albania and all sorts of things. This is the responsibility of the schools in

which we are failing in many cases, but there is a lot we can do, and it is important not to despair. It is very important to realize that young people do look to us for guidance, and they look to us for guidance whether they are in the suburbs or in the inner city, and the power of a good adult role model, mentor, helping hand, is one of the most powerful things there is.

A study in the New York Times about a month ago was made of people who made it against the odds, people who, by demographics, by socioeconomic background, seemed doomed to failure. This was a profile of such people who had made it. In every case, there was the intervention of a responsible adult. Sometimes it was the parent, sometimes it was grandmother, uncle, sometimes it was a stranger, a local policeman or counsellor, and that one person was enough to stem the tide for that individual. So let us speak candidly, let us share what we know and let us as sure as heck not give up on our young people.

In the whole area of sexual activity, let me just mention one statistic. At age 17, 70 percent of our young women have not engaged in sexual intercourse, 50 percent of our young men have not engaged in sexual intercourse. The way you hear some people talk about our teenagers, you would think they were all engaged in sex all the time. That is not true, and let us remember that when the social scientists measure sexual activity, sexual intimacy among young people, they are talking about one incident. Many young women and some young men -- the data I have seen suggests it is more prevalent among young women, but it is also prevalent among young men -- after their first sexual encounter at a young age, feel -- and I guess I do not have to tell you this -- feel very ambivalent about it. There, again, is an opportunity for adults to teach.

DR. CRENSHAW: It seems to me there are two issues that often get lost. One is that the differences that seem so wide are usually more a matter of emphasis on, you know, a matter of emphasis -- where you put your greatest push. Secondly, on the question of what is feasible, what is realistic, what is achievable, and there is debate about that, too. If there could be some private forum because in public it often seems that sparks fly and people dig into positions, but if key leaders could get together and sit down with the objective of advancing that common ground even if not complete agreement can be reached, it seems to me we have already made an enormous amount of progress. We do not have too awfully far to go to get to a place where we can pull together as a society more and better than we are doing today. Thank you.

SECRETARY BENNETT: I agree. I think that in these discussions, the reason I mentioned candor first is that for public discussion, for recommendations in this issue and related issues to be taken seriously, we have to speak in ways that

recognize the differences between censorian public utterance and the way people talk when they are in private, and we have to try to capture some of the sense of what people feel and believe but may not say publicly.

Take the example of teenage sexual activity. I have had some people say to me privately, who would never say it in a public forum, well, this is all well and good, but you know, in the ghetto, all those girls do it. Well, that is not true, it is just flat not true, and we need to come to grips with that kind of statement, that kind of utterance and recognize that you do not write off an entire group of people. Do not treat people as a category when you talk about what works and what is effective, but again that requires candor.

We can take you to some inner-city elementary, junior high and high schools where there is not only a darn fine academic program, there is a darn fine program at making people realize their responsibilities as human beings, where there is a good sex education program, where there are lots of things that are making and forging good, responsible adults, and we need to have those positive examples before us. Sorry to be long-winded on that.

CHAIRMAN WATKINS: Dr. Primm?

MR. PRIMM: I wanted to particularly ask you about your statement that drug addiction among our youth was down. On what do you base that information? From the Michigan report on the high school senior survey, you talk about high school seniors. And of course there are household studies that have been done. But there are a lot of people left out of those as you well know. In my community it is not down. In areas that I travel to in other parts of the country, it is not down, particularly in black and Hispanic communities. When we talk about it being down, I think we lull the American society into a complacency about drug abuse and as a consequence, communities that I serve are often cheated in that process because we do not do any follow up or go to drop outs. They end up in my program which brings me to the second point that I want to make, and that is about treatment.

In your opening statement you talk about treatment. You later on in the second to the last paragraph of your written testimony go on to say treatment is necessary. You also allude to using responsibility. In our country, we know that the education about drug abuse in schools is not that good and particularly in city schools. I have participated in those programs myself.

They have generally been not sustained efforts through elementary, junior high and high schools, and as a consequence, I think we have never really given what we should have in this

nation to drug abuse treatment, to drug abuse education, and therefore we end up at the end of the pipeline where a lot of people are addicted to drugs. I did not want you to go away feeling that there was not a dissenting opinion to maybe what you have espoused here today.

SECRETARY BENNETT: I do not think we disagree, Dr. Primm. If my remarks suggested to you that I was complacent in the drug situation, I would be shocked. My views about the drug problem, particularly lately, have been called a lot of things but complacent they sure have not been called. We are awash in drugs. Our cities are awash in drugs, and as I said to the first question from Dr. Walsh, I think in our inner cities particularly, which is what you are talking about, I take it, I think drug use is up, and, as I mentioned, crack use is up. The data is the data from Michigan, the NIDA study confirms the later point. I think, frankly, that we have had some effect in some communities in terms of attitudes and among some kids. I think some attitudes have shifted. But I would never want to be identified in the complacent category for drug use. As I said yesterday, we have to up the ante, we have to be prepared to do a lot more in our war against drugs.

In terms of drug education programs, we estimate about 80 percent of our schools now have drug education programs, and they are of varying effectiveness. They are like sex education programs. We find, and we think the research is pretty clear on this one, Dr. Primm, that drug education programs without good, sound school policy are of no effect. There was a story in the paper not too long ago, a couple of students sitting in the classroom with their beepers, and some other students came into the schoolyard and hit the phone or whatever it is, the beepers went off, the students went out, made their drug sale and came back to class. The class they were coming back to was a drug education class in which these professional pushers were learning more about drugs thanks to public funds so they could be more effective dealers.

As we have know from time immemorial, knowledge by itself, the grasp of the facts by itself can be used for evil as well as for good. Policy is the key to getting drug use down. If you want to get drug use down in your schools, you have got to have tough policy. You have to do what they do over in Anne Arundel County. They have very clear rules. If you are a pusher of drugs, you are expelled, you are gone, and you can go to some alternative school or reform school, but you forfeit the company of your peers. If you use drugs, you are suspended for five days. If you use them again, you are expelled and you go to reform school. We have seen this be effective in a number of places. It is only because of the times that we have lost sight of what is obvious: young people listen to what we say but they

really pay attention to what we do.

Many of the nation's campuses are awash in drugs. Dormitories are, in many places, havens, dormitories on campus. I think this is a very serious problem because I think the little kids look up to the big kids but if a college adopts a policy of no drug use, the students will listen. But what they will wait and see is whether the authorities are serious and what authorities have to do, college presidents and others, is act in ways that show they are serious. If this is killing our children and some adults, if this is leading to a greater transmission of the AIDS virus and other things, then we have to get serious.

DR. PRIMM: Thank you.

SECRETARY BENNETT: Thank you.

CHAIRMAN WATKINS: Ms. Gebbie?

MS. GEBBIE: One of the areas we have heard about from time to time is the potential of strengthening what we are trying to do by the HIV infection and, in fact, also what we are trying to do about drug addiction by looking at a more comprehensive health oriented education for people rather than a sort of disease of the month approach. I would appreciate some comments from you on your views of a comprehensive health education curriculum that might start very early and be supported throughout education. Depending on how you feel about it, if you feel positively about it, what might be being done through the Department of Education to support that?

SECRETARY BENNETT: Sure. I think it is an interesting idea. I agree with you about the sense of dissatisfaction about the problem of the month. You know, our kids start cracking up on the highways so we put in safe driving courses. They start drinking so we put in a special module or unit on alcohol abuse, sex education module, now an AIDS education module. One wonders what the next one will be. I do not fault the schools for responding to this kind of situation, indeed we have suggested in many cases that they should. But there are two problems with it. One, it seems rather piecemeal for one thing and then another thing and then another thing.

And second, we do not know what they are going to be facing in the future. This may educate them well about this problem in 1988 in the fifth grade, what will they be facing in 1995 in the 12th grade? I think that we recommended before in a publication that a comprehensive program of health education -- I paused because I know Admiral Watkins is very much associated with the wellness campaign of the Navy, that is when we first met -- which talks about the importance of keeping oneself fit internally and externally, and I think that efforts at such

comprehensive programs are probably a good idea.

In many of these issues whether we are talking about safe driving or AIDS education or sex education or drug education, there are a lot of common elements. Again, I go back to the National Research Council. Who are you? Who do you want to be? What kind of a life do you want? What do you think is possible for you? This is, again, so critical, not just to sexual activity or possible drug use but to everything a person does. If we could isolate as teachers, educators, that part of a person which will keep that person safe as best we can judge, we would be working very hard on those things which will enhance self esteem, enhance self worth, a feeling about one's person, that it is important and precious. But to do that, we have to do the kinds of things in our schools that are not being done in too many of our schools.

For example, a lot of the low self esteem from a lot of kids in poor settings in cities or in rural areas comes from the fact that their schools are not serving them well in terms of giving them enough opportunity to have self esteem, they are not teaching students well enough. They are not giving these kids a sense of their future, of their possibility. But we all have our mortal sins. My view of a mortal sin of the classroom, this is a small m, is the teacher or principal who takes a kid in the third grade and says, "You are poor, you are minority, you are all from single parent families. You cannot make it. Forget it. You do not disrupt this classroom and I will not give you a lot of homework. We all know you are headed for welfare anyway so you keep the peace and I will not lean on you too much."

That is the end. That sends those kids a message about who they are and what they are going to be which is not merely going to translate into academic work. This is going to translate into how they behave outside of school, sexually, or in terms of drugs use, or in terms of everything else.

MS. GEBBIE: I think that is well said. I think that what has to go along with that is factual information as well as some of those attitudinal things you have identified.

SECRETARY BENNETT: Sure.

MS. GEBBIE: My second question relates to how we make the best of the federal bureaucracy that we have available to us. You have already referred to the fact that sometimes media coverage exaggerates differences rather than commonalities, and some of the differences rather than commonalities between what goes on in the Department of Education and what goes on in Health and Human Services, do get a fair bit of publicity.

We have found at the state and local level that a good

deal of collaborative effort between school districts and local health departments has to go on to make anything work. I would appreciate your comments on that interaction between the health and education bureaucracies federally and whether there are some barriers that are a problem there, or some things that could strengthen the collaborative efforts of health and education on behalf of our young people.

SECRETARY BENNETT: I am going to ask John Walters who is the Department's representative to the Interagency Working Group to comment on that.

MR. WALTERS: Generally speaking, we have got to remember that a lot of these programs for AIDS that the Federal Government has undertaken are new, so there is going to be a period of trying to establish relationships and get people working together. There has been a good deal of cooperation. There is a problem caused by the fact that Congress has chosen to put essentially education responsibilities for AIDS in one agency, and it is not the Department of Education. We have provided consultation, but there are still people who have to administer the funds and set up the programs. We have tried to provide advice when we have been asked to, and we have cooperated in the evaluation and the formation of some of these programs.

I think, if you are asking can we do more, I think we can do more to work together on some of these things. There has been some reluctance on the part of some health educators to move beyond the issue of simple factual information and talk about the ethos of the school, the issues of building character, the issues of building self esteem, because those are not common areas where they have a lot of experience. And we would like to see more involvement in the direction of some of the tenets in AIDS and the Education of Our Children, but we are very pleased, as the Secretary mentioned, to see that the CDC guidelines reflect a lot of those same principles. So we are moving in that direction but I think we will make more progress.

MS. GEBBIE: May I ask one related question? To what extent in that process do you bring in a variety of state or local education officials to participate in that process? I am more familiar with the experience on the health side which is if we do not find people with a range of views from a range of geographic areas to sit with us and consult, we often get into very confusing problems. Is that a similar process on the education side?

SECRETARY BENNETT: Well, again, we have not been charged by Congress or given any funds to do this. So whatever we do, we do on our own. We have consulted as widely as we could. When I travel, this is one of the issues I talk about with school officials. I think it is important for Department of

Education to have a voice here, a voice in this issue because the Secretary of Education, Surgeon General, Secretary of HHS, might have, indeed ought to have, given their responsibilities, somewhat different lenses and perspectives on this but whatever we have done, we have had to do in a somewhat ad hoc fashion because we do not have any money specifically dedicated to this problem.

CHAIRMAN WATKINS: Dr. Lilly?

DR. LILLY: First I would like to briefly pick up on the point that Dr. Primm was talking about. I do not think you really meant this literally, but I wrote down that you said apropos of the IV drug problem that without responsibility, meaning responsibility on the part of the individual, we will be in the treatment business forever. I do not really believe that you think that we are ever going to be out of the treatment business either for IV drug abuse or for sexually transmitted diseases, that there exist tactics, short of imposing the death penalty, for avoiding those altogether.

SECRETARY BENNETT: You mean, you are saying we will be in this business forever?

DR. LILLY: Yes, to at least an extent.

SECRETARY BENNETT: Right. Of course we will, but the point, was that not only will we be in this business, but if there is not more emphasis on user responsibility and prevention, the business will be ever larger.

DR. LILLY: Okay, fine. Then my main question has to do with the idea of standards of conduct. I am very much for standards of conduct. I would like you to develop this a little bit, your ideas about what kinds of standards of conduct should be inculcated for homosexuals.

SECRETARY BENNETT: What kinds of standards of conduct should be inculcated for homosexuals? In the schools?

DR. LILLY: Right. What kinds of standards of conduct would you teach of homosexuals?

SECRETARY BENNETT: Homosexual students in the schools?

DR. LILLY: All homosexuals.

SECRETARY BENNETT: Well, I am Secretary of Education, as I said, my focus here is on talking to young people.

DR. LILLY: Presumably what you are trying to teach

them in school is what you hope they will practice as adults.

SECRETARY BENNETT: Yes, but it is very important, Dr. Lilly, to distinguish: A) my responsibilities which are to talk primarily to young people, and B) what one says in different situations. I think as the message of AIDS and the Education of Our Children makes clear, we want to teach young people restraint and self control and when they are young, abstinence. I think that is pretty clear and pretty straightforward.

If you want me to comment about homosexual activity, homosexual behavior generally among the adult population, I think as a citizen, I would feel very much along the lines that Randy Schiltz wrote in his book, that widespread promiscuity certainly is not helping in the struggle against AIDS, and that the counsellors and doctors at clinics for gay men who counsel people to exercise precaution, to use condoms, to exercise restraint, are teaching the right kind of standards. I identify with that 100 percent. Wouldn't you?

DR. LILLY: Indeed.

SECRETARY BENNETT: Good.

DR. LILLY: Given the fact that in going through your pamphlet, there, of course, is no mention made of potential homosexuality and that may or may not be justifiable within the context of children --

SECRETARY BENNETT: I am sorry, I did not hear, there is no mention --

DR. LILLY: I say, within the context of this pamphlet that you have put out that there is no mention of potential homosexuality. I think insofar as teaching in school though, in fact, many kids know already at that age that they are homosexual.

The other thing that somewhat bothers me about the pamphlet is there is never any allowance for an alternative to the classical family, and as you know, homosexuals are, nowhere that I know of, allowed to get married and thereby establish a classical family. There was a Commission recently that recommended to the President that homosexuals not be allowed to adopt children.

SECRETARY BENNETT: Well, again, the book is not basically about family structure, it is about what should be said to young people in regard to --

DR. LILLY: It refers extensively to family structure which I am all in favor of. I think families are wonderful

things.

SECRETARY BENNETT: I think they are, too. We are both pro-family. That is good. I do not see the significance of the point. You do not think I understand that there are different kinds of families? Of course there are.

DR. LILLY: I am not quite sure you understand the problems that homosexuals have with families and trying to establish a family structure that is recognized by the world abroad.

SECRETARY BENNETT: I am aware of their complaints about this, but I do not see that it is particularly germane to the book. Do you mean the book should recommend that in talking with young people about AIDS it should emphasize or stress more than it does the homosexual family? I do not see any reason for doing that.

DR. LILLY: I think I have made my point.

CHAIRMAN WATKINS: Ms. Pullen?

MS. PULLEN: Would you elaborate on your comment concerning equivocal messages and how you view the comparative utility of equivocal messages in addressing AIDS, particularly for young people, versus messages that are consistent.

SECRETARY BENNETT: Sure. What I mean by equivocal is trying to stress to a young person that a certain kind of behavior is not right for them because of their age, because of their immaturity, or because of possible consequences. And if one says this in a kind of incantation, say the context here is a sex education course, then proceeds to talk for the duration of the class or the lecture about ways in which one can protect oneself one is sending an equivocal message. I am not saying that should not be done if that is what the community decides it wants to do in the area of sex education or instruction about AIDS or teenage pregnancy. The community is free to do it, the Secretary of Education cannot make them do otherwise and would not want to make them do otherwise, but I think there is a problem with equivocation.

In the same way, if one said, "Look, do not smoke, but if you do, smoke low tar cigarettes. Do not drink, but if you do, keep it to 70 proof". I think these are confusing messages for young people. That is what I mean by equivocation.

MS. PULLEN: What do you see in young people in particular as the effect of an equivocal message?

SECRETARY BENNETT: Confusion. It is a, as William

James said, a blooming, buzzing confusion out there for all of us, the reality, the world. For young people, it is particularly difficult, and in the world of television, in the messages they are getting from radio, from movies, from lots of things, there is not a lot of steady ground out there. There is not a lot of steady, reliable, cultural support for, if you will steady and constant behavior.

The best thing that an adult can do for a young person in this regard is to speak in a steady, steady and clear and firm; manner standing for something and hopefully standing for the right thing.

MS. PULLEN: Thank you.

CHAIRMAN WATKINS: Dr. Lee?

DR. LEE: Mr. Secretary, let me start off with a plea. We had a panel here yesterday talking about abandoned, homeless, runaway kids that made an unbelievable impression on me. Ms. Bucy said, and made the excellent point, that they are running from things, they are not running in search. They have extraordinarily abusive and deranged family structures. The title of her book is, To Whom Do They Belong. I know they belong to me; I know they belong to you; I know they belong to everybody in this room; and they are the least of these. I am not a particularly religious person, but I make a plea to you to try to help these people who are working with these kids. I know you are. They need more help than they are getting.

This leads me into my question which I could easily ask of every panelist who is going to come before us today, and I do not have time to elaborate. I will just say large parts of our public school system appear to me to be custodial in nature. The Western civilization, most of Western civilization and Asia do not operate on this. Excellence is rewarded, poorer students are funneled in different directions, etc., etc. Personally, I would strongly favor revamping our whole educational system and going for that type of thing. But what do we do with the kids that are shunted off. Do we send them to trade schools? Do you have ideas on this type of thing?

SECRETARY BENNETT: Yes, sir. I agree with you about where you started. I think not only is it my responsibility in this job, but it is part of the best response to these children that we take a very good and hard look at the educational system. You are absolutely right that a lot of these schools are custodial, and the reason that a lot of them are custodial is that they do not have sufficient incentives to be anything else. You see, this is the basic problem with American public education. If you serve up a rotten hamburger to kids in this society at your restaurant you will be closed down by local,

state, federal authorities. If you serve up rotten education to 10,000 kids a year in a district in Chicago, nothing happens. Now, you want to talk about consequences to the lives of children in the area that this Commission is addressing and other areas, I will give you a very powerful predictor, the quality of those schools.

Let us take an example. $4,000 per child was spent in Chicago in the public schools. Fifty per cent of those kids dropped out, the kids you are talking about. Of the kids who remain, 50 percent of them score in the bottom one percent in the United States in standardized tests. Do you know where they are going? A fair percentage of them are going into crime, a fair percentage are going into delinquency of various sorts, into drugs, into all sorts of things. Could it be better? You bet.

I could take you to some schools -- some of them are parochial schools in Chicago, a couple of them are public schools -- that take the same population of kids, from the same neighborhoods, and 80 percent are graduating, 90 percent are graduating, 85 percent are going on to college. Those schools are blessed with good principals, with good teachers, with a high degree of parental involvement. But the other schools are not. Is there any penalty? Is there any penalty for wasting five or six years of a child's life in our system? There is no penalty whatever. We have said that there should be penalties, that people who do not teach children, who do not run schools that are

effective, should be fired. This turns out to be controversial. Fine. It can be controversial. We can debate this ad infinitum.

Meantime, there are lots of schools that are doing nothing but destroying, not only children's educational opportunities, but their life chances in this area and every other area. We want accountability in education, and that will require some tremendous changes. You know, it is interesting you use the word custodial because there is a big debate in New York City going on right now about who runs the schools, and some people believe it is the custodians' union in New York that runs the schools. It seems to the be most powerful group. If you want to have a special session in New York on some problem, AIDS or drugs, you cannot do it unless the custodians say you can.

DR. LEE: But my question was what do you do with the people that are winnowed out of the school system, and if we do it right, a lot will be winnowed out?

SECRETARY BENNETT: First of all, if you do it right, if you have good schools, you are going to have fewer dropouts than you have now. We do an annual report card. We call it the wall chart, Dr. Lee. We find that the better the school -- the more demanding the school, the higher the quality of teaching,

the more rigor -- the lower the dropout rate. Most kids do not tend to leave because it is too demanding. They leave because it is boring and they leave for something that they think will give quicker thrills outside, but there are a whole range of alternatives. Alternative education programs is one of them. Technical schools, trade schools is another one. Another kind of learning environment. We have seen some experiments done around the country where some kids just do not work well in a traditional setting but they work very well in another setting. But the point is to stay at it and not to give up and to have accountability in the system.

We wanted to put in a bounty, we proposed to the Congress a bounty. If a kid who has dropped out of school is reclaimed --

DR. LEE: You proposes a what? I did not hear.

SECRETARY BENNETT: A bounty, the bounty system. It works for dropouts. A kid drops out of school, another educational institution -- Catholic, Jewish, non-sectarian, trade, technical, we do not care -- reclaims that child. That is, finds that child, and graduates him, reaches certain standards, that school gets the per capita expenditure for that child after he graduates -- an incentive system. It did not go anywhere on the Hill because the established educational interests, of course, hated this. The very idea of competition in our educational system is regarded with some, not with some dismay, but as anathema by a lot of the educators. We can do this, we can do this. The success stories in our schools show that it can be done.

There may not be a greater story than that story in Los Angeles of Jaime Escalante, a poor Hispanic neighborhood which was low performing, very low performing until the mid-1980's. A new principal, a new superintendent, a new math teacher. Kids who before had been dropping out, very high dropout rate, there are now almost no drop outs at Garfield High School, are now going on to college, not just college. Eighteen kids presented themselves. Low income Hispanic kids presented themselves to the college board people to take advanced placement in calculus. They took the test, 14 of them passed. The people at Princeton, suffering from the same stereotype a lot of people do, said, somebody said, not all the people, somebody said, hey, this cannot be, you are poor low income Hispanic kids. You cannot take advanced placement in calculus. They had to take the test again. They all got advanced placement in calculus.

Why? Because you have a few possessed teachers. I have met them and they are possessed, they are rational but they are inspired and enthusiastic people. They have said, "Although you are low income Hispanic kids we are not going to let you

down; we are not going to let you die; we are not going to let you get into drugs; we are not going to let you get into pathology; we are going to get you into calculus." I went out there and visited that school. They are doing it. It can be done.

Do you think that teacher and that principal are getting one cent more because they are successful? Not one cent. Do you think they are treated with regard and acclaim by their colleagues? A lot of their colleagues do not like them because they were successful and they put the lie to a lot of excuses that are going on. You can put all the responsibility you want as a group on the educational institutions if it is something proper for the educational institutions to do and I will take it because they are very powerful predictors of what people can be.

If I can just make one other comment. There was a belief in the 1960's and 1970's that socioeconomic class was destiny. Where you were born, whether you came from an intact family, or the color of your skin was destiny. The research now is pretty clear. Socioeconomic background is a fairly strong predictor of what is going to happen to you, but schools can make an extremely positive difference in all aspects of a young person's behavior. Give people a really good school, and you can overcome an awful lot of deficits.

CHAIRMAN WATKINS: Mr. Secretary, I know your schedule is busy. We have to close out, I will close out this particular part of the hearing with a few questions. First, I would like to make a statement about the drug treatment we have recommended. It is a comprehensive drug treatment effort which includes resources to go into counselling that would certainly include behavioral change recommendations. Without it, there is no drug treatment. So we are in total agreement, I think if you read our package you will see it is quite an integrated package -- and certainly does not avoid the tough issues that you brought up.

The one compelling thing that has come before this Commission is the wide divergence in educational treatments that are necessary to reach the real situations existing in the nation today. So if the nation were to accept, let us say, the Bennett model for the year 2000, if we were to pursue that, we still have to get from the photograph of the nation today to that point. The people that come before us state that there have to be a variety of educational intervention concepts in the nation to be able to pull kids out of the mainstream, back into the mainstream, to get people that are out of the workplace and illiterate, literate and back into the workplace.

The whole range of cultural differences have to be addressed. The various educational packages have to be sensitive

to cultural differences. It is difficult -- even if you have an end product that you are trying to achieve -- to understand how we get to the point where we reach the self esteem, the personal worth and dignity, the concepts in the mind of the child. We are all familiar with the problems of teen pregnancy -- light birth weight, cognitive development problems, lack of participation in Head Start -- we have a whole host of medical issues that the Department of Health and Human Services' 1985 report, stated that we have to address. Otherwise we are going to have big educational problems that are not just teaching values. We do not have the baseline built into the young people today, particularly as the demographic changes take place and the ethnic groups grow in size such as the Hispanic group.

As we go around and listen we have people ask us the question, "Why is Dr. Koop here and Secretary Bennett there?" My answer is "I do not think they are that far away from each other." I really believe what we need to do is destroy that perception and bring you into harmony because I think both are right. We heard Dr. Koop tell us the very thing you would tell us, but he walks through a different logic train, down into the swamp that we find ourselves in in so many places in our society today, and tries to pull us back up towards the same worthwhile, objective goal that you have. It seems to me that there is an opportunity here to make positions mutually compatible instead of mutually exclusive as we all move together to try to achieve a better society, perhaps by the turn of the century, and set our sights on some long range goals to achieve what you are saying. But how do we get from here to there is what this Commission probably is all about.

I would like to have your comments on that because I can tell you that the perception of divided leadership is a real issue brought before this Commission. It is not this Commission's position. We hear it from persons with AIDS, from community-based organizations, from school districts, from state leaders, and whether it is real or non-substantive, it is a perception that is very powerful out there. It seems to me there is an opportunity now to try to weld these things together in a more integrated, longer range plan which allows flexibility and educational intervention strategies which may not be able to achieve your objective today but might be able to achieve a longer term objective. I would like to have your views on that.

SECRETARY BENNETT: Sure, just a couple of things. I am not just giving you a photograph of what it would look like. We have been, I guess, doing little else for three years, but trying to say how to get there. We have a whole list of publications, apart from the AIDS publication about what works in schools; how to make them work, how to make them more effective. There is no mystery about this. This is not a problem of not knowing the state of the art, not know the science. We know what

to do, we know how to make schools better. The problem is dislodging certain very strong political interests right now. The educational establishment in large part does not want to do what it needs to do.

Do you want to know what that really is, apart from all the bureaucratic talk? It means people have to get fired. Principals who are no good have to get fired. It means teachers who are no good have to get fired. Counsellors who do not counsel have to get fired, and people who are doing a great job teaching and principalling and counselling need to get higher salaries and need to be recognized for that, but that runs against a great current of thought in a lot of the education business. But I can get you there. You make me education czar, I can get you there. Now, I do not want to be education czar. It is a free country, and at the state and local level, I think there is an enormous consensus among the American people, if you will, on my issues, the education issues, plus I think enormous agreement among the American people on our approach to this issue. What is not missing here is political consensus, or public opinion rather, but the willingness to act, the willingness to do it.

In terms of leadership and the perception of differences of leadership, again, Dr. Koop and I are extremely close, very close. Some people have an interest in exaggerating the differences and disagreements between us, but with that said, then I think Koop and I agree 95 percent of the way. I would just say two things. It is all right for a Surgeon General and the Secretary of Education to speak a little differently about these things. Think of Koop and Bennett, if you will, at the level of the school, not talking to an entire country, but talking to an individual, a young woman, a young man, goes to see a doctor and talks about what he or she is doing. The doctor's advice and the doctor's recommendations might be different than the recommendations given by that young person's counsellor or teacher.

The doctor's advice would probably emphasize the medical aspects, it probably should. That is what you go to a doctor for. The teacher or counsellor's advice might emphasize other things, but the teacher or counsellor should talk about it. So some shading of difference I think is okay.

Second, some measure of disagreement is okay. I think it is critically important, you did not ask for my advice to the Commission, but I will close in just 30 seconds. It is much more important to acknowledge candid disagreement if there is such than to try to suggest that on this issue, or other issues, but this one particularly, that everybody is unanimous, everybody agrees in terms of points of emphasis and so on. The American people, when they ask for leadership, I do not think they are

saying we are a bunch of dummies, tell us what to think. They want to know our best thinking and if our best thinking is divergent on some points, they can handle it. They can live with it. Every four years, they listen to divergent thinking when it comes to an election and they make up their own minds. I think the points of agreement, Mr. Chairman, among the members of the Commission, will have more credibility where they are unanimous if, when there are points of disagreement, that one does not try to paper over them.

CHAIRMAN WATKINS: I could not agree more with that. I was just trying to ferret this out because there have been a constant barrage of witnesses in this regard. I will close it out with a last point and that is that you talked a little bit about how Congress has not allowed dollars for a certain integration of education health promotion from the Surgeon General and HHS side to the Department of Education.

Have you, in fact, come together and found that there is a strong need to reinsert into the schools in a more comprehensive health education, health promotion curriculum at this particular time when all the projections are so serious on the health of our young people so that they impact significantly on their potential schoolwork? Have you explored a much more coordinated HHS-Department of Education effort to look at health education in a very fundamental way, not in a band-aid way, but something on the order of human biology, a life science continuum, from preschool all the way to baccalaureate, at the right level of maturation, trying to encourage some kind of a better understanding of our own human biology in which to place all these various things? How aggressive has that been and have you been turned down for dollars you have requested to do that kind of thing?

SECRETARY BENNETT: No, we have not requested dollars. The reason I mention it was not to pout or complain about dollars, only that when Congress turned to us and said, we need to hear something about education in AIDS and then did not give us any wherewithal to do it, that was a bit of a problem. Now, it did not cost anything to write the book, but it does cost something to publish and distribute it.

I think our cooperation with HHS is pretty good. Our noses are not out of joint because we are not a lead agency. It is fine for HHS to be a lead agency, as long as we can get in and as long as we can talk, as long as we can make the suggestions we made. As long as I can get the Surgeon General or the Secretary of HHS on the phone, and say, hey, there is a couple of mistakes in your book, you had better change them, at least we think they are mistakes based on CDC data, that is all we are seeking, just that kind of access.

In terms of the schools, remember we do not have any authority to dictate curriculum. In fact, we are proscribed from dictating curriculum. But we can and I think what we should do is identify what we regard to be model programs, both in general terms as we have done in the book and by pointing to schools and districts that are actually doing things that we could make successful elsewhere. That is, I think, probably the best way for us to continue to act.

CHAIRMAN WATKINS: Thank you very much, Mr. Secretary, for being with us today.

SECRETARY BENNETT: Thank you.

This morning we have the subject of AIDS and education in the nation's schools. Dennis Tolsma, Director, the Center for Health Promotion and Education, Center for Disease Control; Jonathon T. Howe, President of National School Boards Association; Manya Ungar, President, National PTA; Connie Hubbell, Kansas State Board of Education on behalf of the National Association of State Boards of Education; Dr. Cherrie B. Boyer, Assistant Professor, Department of Epidemiology and Social Medicine, Adolescent AIDS program, Albert Einstein College of Medicine, Montefiore Medical Center; Debra W. Haffner, Director of Information and Education, Center for Population Options.

On the panel here this morning, because of the numbers of you, please restrict your statements to about five minutes. We have asked you to do that so we have time for dialogue. So we will start now with Mr. Dennis Tolsma.

MR. TOLSMA: Thank you, Mr. Chairman. Obviously, if AIDS is the national priority, all institutions of society need to be involved in it. Such institutes in our society therefore include our schools and the organizations that serve young people.

The risk of HIV infection among adolescents is determined by two things. One is their behavior, what they choose to do, particularly with regard to drugs and sex, and the other is the prevalence of infection among people with whom they choose to interact. I will not go into my statement in detail in that regard but clearly there are data about the prevalence of HIV and AIDS among young people, and there are data about the prevalence of behaviors that place them at risk of AIDS.

The nation's systems of public and private schools, the organizations that serve the education and health needs of youth, both in and out of school, have vital roles to play, and CDC is instituting a number of activities to insure that educators nationwide have accurate information about AIDS and HIV transmission. The CDC program is based on a successful 15-year

history of working with the nation's schools to protect and improve the health of young people. However, in 1987, we launched an $11 million program in education in preventing the spread of AIDS. The budget for fiscal year 1988 is $29.9 million and next year will be $36.5 million. It is, however, a program built on working relationships with state and local education agencies, with our nation's public health departments, and with other organizations in the nation.

I will mention only briefly that today we are providing financial assistance to 15 state education agencies and 12 local departments of education. By this time, well, not by this time next year, in a few months, we will be extending this program to all state education agencies in the nation. In addition, I would like to mention to you that we have made awards to 15 private sector organizations, some of which are represented on this panel this morning. I just want to highlight one aspect of the awards made to national organization. Five of those fifteen organizations are either minority organizations or organization whose programs are directed in very substantial measure towards meeting the educational needs of minority adolescents.

I want to mention briefly behavioral sciences in the evaluation. We need to know both what we can do and what we are doing. In addition to intramural work that we are carrying out in our center, the contract has been awarded to the National Academy of Sciences. The purpose is a systematic assessment and summary of the most important behavioral research that has been and is currently being conducted nationally and to identify additional research to prevent HIV transmission in children and adolescents. That effort will be completed in September of this year. In January of this year we issued guidelines for effective school health education to prevent the spread of AIDS. The document is called the CDC Guidelines and, in fact, they are a collaborative product of multiple state, local, and national education and health agencies. They contain information and recommendations to help educators and others implement a package of programs. I will not go into them in detail. I merely wanted to highlight two or three of them that I think are important, although all nine of the recommendations are important.

The first is that parents, teachers, students, and appropriate community representatives have to be involved in developing and implementing education policies and programs.

The second is that AIDS education programs should help students acquire essential knowledge at each appropriate grade. Our Guidelines identify appropriate knowledge of AIDS for early elementary students, for late elementary and middle school students, and for junior and senior high school students.

Another point that is made is that AIDS education

programs should emphasize abstinence for young people and mutually monogamous relationships. Equally important is that education about AIDS should be designed to help teenaged student avoid specific behaviors that increase their risk of becoming infected.

Last, but not least, AIDS education should be developed and provided as an important part of comprehensive school health education. Perhaps I can just take a couple of minutes to emphasize that last point. Of course we should provide information, but information alone is not going to get the job done. The essential information in the guidelines is presented, can be presented in a brochure, a pamphlet, a 15-minute lecture. We cannot delude ourselves into thinking that providing information as an isolated topic on a one or two time basis is sufficient. It is not, and the guidelines do not suggest that it is. We argue that AIDS education needs to be carried out within the framework of a comprehensive program of school health. Comprehensive programs establish the foundation for understanding the relationship between personal health and personal behavior, based on an organized, sequential, developmentally-appropriate curriculum, preferably from kindergarten through the 12th grade.

We have studied the benefits of comprehensive school health. We have carried out a randomized school health education study. Leading evaluation experts say that this is the most careful study of its type even undertaken. There were 30,000 young people in the schools included in the study. Just to illustrate a major finding, the study showed that exposure to comprehensive school health education resulted in a 37 percent reduction in the onset of smoking among 7th grade students, 13-year-old students. Let me be clear about this. This curriculum was not a categorical tobacco education program. It was comprehensive school health education approaches.

We are convinced that we educate better about AIDS and to better ends if we incorporate AIDS education into a comprehensive approach, a curriculum that provides a context for children and adolescents, to understand their bodies, their feelings, and the factors that influence them for good or ill. We are talking about what you said, Mr. Chairman. We are talking about promoting a sense of self-worth. We are talking about a curriculum that equips young people with skills that are crucial for making positive behavior choices, such skills as decision making, such skills as communication skills. We are emphasizing that today. We are going to continue to emphasize it, and we know that just saying it is good is not necessarily going to make it happen. It is going to take a lot of effort on the part of educators and on the part of those who work with them to get this accomplished. It is not easy to influence the nation's youth or we probably would not need to hold this series this morning.

Recently, a 17-year-old girl sent a note to the staff at the Center for Health Promotion and Education. It was short and to the point. She wrote, "I truly believe that monogamy would be the best way to slow the AIDS virus down. I wanted to keep the same sex partner for my whole life but I messed up." Well, adolescents often learn by experimenting and taking risks but it is for all young people who are growing and developing into independent adults that we join forces in this local, state and national partnership. We know we will succeed when community after community across the land undertakes to education children well about health, helping them to develop the knowledge, the skills, and the support they need to take the responsibility for their health. If we fail in this, we will have failed one of our most fundamental responsibilities, and that is, protecting the nation's youth. Thank you.

CHAIRMAN WATKINS: Mr. Howe? Thank you, Mr. Tolsma.

MR. HOWE: Thank you, Mr. Chairman. I am Jonathon Howe. I am President of the National School Boards Association, and I am a member of the Northbrook, Illinois, Board of Education. I appreciate this opportunity to appear before you today. The National Schools Boards Association is the only major educational organization representing some 95,000 school board members in the 15,000 plus public school districts in this country.

I would like to emphasize a few points, if I may, in our written statement which has been submitted for the record. The National School Boards Association is indeed proud to have been an early leader in encouraging education about AIDS. We work to prevent the further spread of AIDS and today the only way that this can be done is through education.

Briefly, NSBA believes strongly in the need for educational programming to combat AIDS. We believe that a high quality AIDS curriculum emphasizes accurate, factual information, and the need to avoid high risk behavior. We believe AIDS education should be a comprehensive program that begins in the early years, and continues through high school. We agree with CDC in their recommendations which you have just heard.

We believe that AIDS education should be something that is founded upon community involvement and that it meets the needs of the community. All children must receive this type of education. Leadership at the national level is equally essential.

NSBA does not believe that there is one magic formula for AIDS education. It can be taught in health classes; it can be taught in science classes or even in social studies. Dimensions of the issue cut across different disciplines. It

should begin in the early years with discussion of infection, progressing logically to discussion of the actual disease itself in the middle school years, and then to specific preventive practices as well as the social issues involved. AIDS instruction cannot be a one-shot, once a year deal. Research about student learning indicates that the retention rate for such information received that way is very limited.

Quality instructional materials must be made available. Beyond the basic perimeters, the details of each district's AIDS curriculum are issues appropriately addressed within the local school district. In my written statement, I list a number of criteria that local school districts could use to develop their own AIDS education programs. Many local districts will look to outside resources as they develop an AIDS education program, and I, too, believe a model curricula that can be adapted to local communities can be very useful and should be undertaken.

In my written statement, we have indicated some 10 criteria that should be used in developing the model curriculum. What do school districts need to meet their obligation to provide AIDS education? They need good courseware. This is a new and rapidly changing field. Up-to-date courseware and information is essential and the ability to continue to update as research advances is an absolute. The need also for inservice training goes without questions. It is extremely important that all teachers and administrators be well informed with the latest information on AIDS so that they can answer questions factually and, in an age-appropriate manner, answer the questions that students may have.

There are significant costs involved to launch any kind of successful curriculum initiative but the issue is not a local or a regional one, it is a national social issue and federal funding support is not only necessary, it is vital for the national self-interest. A funding initiative similar to federal funding of substance abuse education is very much needed. Coordination with other community agencies is an important component as well. Demonstration programs and projects that stress community cooperation would be very helpful.

The best curriculum in the world is not going to help prevent AIDS if it is not used. I assure you that local school board members are aware of the AIDS crisis and they want to be in the position of being able to provide the right kind of information to the students within the public schools. They are aware that AIDS is a threat of tremendous proportion, and not simply in certain urban areas. It is not a regional or local thing, it is a widespread problem that we have to face.

There is a local dimension to education about sexuality and contraception. A mandate from outside may well fall on deaf

ears. Each community school board is in the best position to assess the type of teaching that will best convey the universal message. I want to make it clear that I do not believe that local school boards see AIDS education as an optional activity, but the how and the when may differ from one community to another. I cannot emphasize too strongly the concerns of the National Schools Boards Association about AIDS education. We believe that this national, this worldwide health risk requires an aggressive educational program.

Education is, for now, the best protection against AIDS. Each of the 95,000 individual school board members in this country and the National School Boards Association as an organization, accepts the challenge to educate our children about this major health problem. Thank you very much, Mr. Chairman.

CHAIRMAN WATKINS: Thank you very much, Mr. Howe. Ms. Ungar?

MS. UNGAR: Good morning. My name is Manya Ungar and I am President of the 6.2 million member National PTA, the preponderance of whose membership is parent membership although certainly we have been long time partners with the educational community and the medical community. So what I have to say will not be new, I assume, to most of you sitting here now.

Obviously National PTA believes that parents play an important, pivotal, crucial, and critical part in all of the AIDS issues. There has to be information, there has to be communication. But we also understand that parents, like their children are in many ways uneducated, not only about the facts and the important technical information about how AIDS is or is not transmitted, but they are also unaware of or have not yet developed the kinds of skills that will make it possible to communicate those facts and, indeed, to communicate their values to their own youngsters.

We have, in another project, talked about parenting as being the underdeveloped skill and therefore, our association, now 91 years old, and founded on the premise that the most important way in which to rear, protect and nurture children, is to have parents who are educated, has taken on gladly the chore of trying to communicate to our 28,000 local PTA leaders, and beyond them to the 6.2 million members as to what AIDS is, how it is transmitted, and how you should go about talking to your children. Even more important, how you can go about assuring that every school board in the United States will adopt an AIDS policy that reflects parental and local concerns but will assure our long term goal that there will be a comprehensive school health education policy with progression, sequence, age-appropriate, faces the facts, and that transmits those

important things like self esteem and self worth which teaches children how to make critical choices.

Therefore, we were very happy to be one of those groups that was a recipient of the CDC grant. But I want you to know, regardless of what will happen in subsequent years and this is not a plea, although it is also not to say forget us, Mr. Tolsma, that National PTA would have undertaken this kind of project anyway on our 50 cents a member per year because we think it is so important.

We believe that parents have to be allies in this effort, or whatever goes on in the school is not going to be effective at all. Therefore, the project that we undertook that is funded, in part, by CDC, is to support parent involvement at home, by providing information to them designed for parent to parent, which speaks to them as non-professionals, trying to tell them what might be good ways for them to learn how to communicate their own concerns and facts and find out what their children know and do not know.

We also believe that it is very difficult for parents to talk many times on what they say is their purview and should be their primary role. But it is tough to talk to your child about death; it is tough to talk to your child about sex; and it is tough to talk to your child about drugs. So parents need to have some sort of guidelines and assistance in how to go about doing just these things.

Through disseminating reports such as that of the Secretary of Education, the Surgeon General, the CDC guidelines, SEICUS and the Life Insurance brochures, we have already started to provide them that information. We also gave them guidelines as to how parents can conduct a meeting on AIDS what to look for, what are the pitfalls, and how to avoid confrontation even before they get to the discussion of communication on this most critical and important issue.

You have, I know, our position statements attached so I will not take your time for that, but we have approached the idea of AIDS in resolutions in our national conventions. I was very proud of the fact that, before AIDS became an issue, first, that National School Boards Association asked me some three years ago as a representative of the parents and the PTA, to come and talk with them about the parent concerns and perspective in regard to AIDS education and whether AIDS should be addressed in board policy. And second I am even prouder of the fact that delegates to our PTA national convention took a very firm stand a few years ago that there should be no ostracization, no further victimizing of the victims in this terrible disease and equally terrible problem that faces us, and that our commitment as adults should be to assure that children are protected, nurtured, and have the

right information about AIDS and that if, indeed, they are themselves AIDS carriers or AIDS victims, that they will be treated with the kindness, compassion, understanding, and help, for as long as we are fortunate to have them with us.

We would ask this Commission and this distinguished panel when you make your final recommendations, to include something which would address the fact that we need continued government support for AIDS education in schools and that means financial resources as well as philosophical support and that we have a policy which encourages confidentiality and protection for those parents and those children who are AIDS victims or carriers and that only under the policies of need to know should that information be shared with the community so that we can avoid the kind of terrible thing that we saw happen in South Florida.

We would urge you also to encourage the government to provide special support for the counselling, and the assistance of those whose children are suffering from AIDS, and to try and face the problem of what are we going to do about those infected babies being born and abandoned by their parents and left to die. We would also encourage research in pediatric AIDS and would hope that your statement would address the research, the education, the continued treatment, the prevention, and support for all people with AIDS. Certainly National PTA has made its pledge in that regard.

I thank you very much for having allowed me to come and participate in this.

CHAIRMAN WATKINS: Thank you very much, Ms. Ungar. Ms. Hubbell?

MS. HUBBELL Good morning, Mr. Chairman and members of the Committee. It is indeed an honor and a pleasure to be here this morning to visit with you about an issue that is very important to all of us. I am Connie Hubbell, a member of the Kansas State Board of Education and currently serve as a board member on the National Association of State Boards of Education. Recently I had an opportunity to participate as a member of the Governor's Task Force on AIDS in Kansas, and served as the Chairman of the Subcommittee on education. I am delighted to be here this morning representing both the National Association of School Boards, NASBE, and the Kansas State Board of Education.

State board members are volunteers who represent a variety of organizations and occupations. We believe we have the opportunity to build a consensus of parties seeking to impact on various issues in our country and especially to impact on the issue of AIDS. NASBE has a five-year contract with CDC to help states develop or strengthen education policies to prevent the

spread of AIDS. NASBE is the only organization that is currently working to help develop state policy. We have a national network that we can distribute that information among all states in the United States. We are also working to assist states in their AIDS development projects. I feel it is essential for states to take a very strong leadership in this deadly disease, AIDS.

When state leaders explain the needs of AIDS, of AIDS education, they inform the public and help prevent individual groups having to go over and over and repeat the need of AIDS education at the local district level. NASBE is also here to help in the serious gap of information that is being distributed from the national level clear down to the local level. Local school districts do not always have the staff, the expertise and the time to put together all the information that is necessary. NASBE as a national organization can help distribute that information to the local levels to help to not reinvent the wheel many different times.

In December, NASBE did conduct a state by state survey that indicated currently 18 states are mandating AIDS education in their schools. This is not a large number of states, but I want you to know it has tripled just since last June. The policies that these 18 states are using vary in comprehensiveness and some of them do still have serious gaps remaining. A few states have provided funding through departments of education for AIDS education. I would like you to know that in Kansas, the Governor has recommended a million and a half dollars in his appropriation budget in 1988 for AIDS education to our local school districts. That is around $3.75 per student to the local schools that has been requested in funding in Kansas.

Few states have addressed the problem of educating about high risk of infection and few states have plans for evaluating and monitoring AIDS education in the local school districts. In November of 1987, the Kansas State Board of Education voted to require AIDS education in all school districts, accredited schools, public and private, by September 1988. We voted this mandate despite our state's strong history of local control. Before we acted, very few districts in our state were providing any AIDS education. I still believe local districts would not be providing it had that mandate not been made.

Under our requirement, local school districts have the option to decide who will teach the information, what will be taught, and when it will be taught. We are mandating a comprehensive, health education, sex education program, including the teaching of AIDS by September 1988, K through 12. When we took this endeavor on in May of 1987, there was tremendous outpouring of letters against the issue to all state board

members. We took the first vote, and it barely passed, six voting yes and four against. Between May and November when our final vote was made, we took the opportunity to educate our publics that we were educating the youths about AIDS, not safe sex. Through this education, our mail turned around entirely. The public understood that this was an incurable, fatal disease, and that education was the only tool that we could use at this time.

When we took the vote in November, 1987, to change the Kansas rules and regulations, it was an almost unanimous vote to mandate AIDS education in all schools in our state by this coming fall. In Kansas, a conservative midwestern, state, we saw the need, we took action before we had an epidemic in our state. We have only had one student in our schools currently who had died of AIDS. We mandated AIDS education because Kansans are convinced that there is no other way to stop this terrible disease.

We want AIDS education to calm our students' fears. Our goal is to provide abstinence and fidelity, to give the children the confidence to say no, to say no to illegal drugs, to premarital sex, we want to address other health issues in our comprehensive program. We want to address teenage pregnancy as well as the prevention of AIDS. As CDC said, AIDS education belongs in a broader context. That is what our state is doing, that is what our National Association of State Boards of Education is advocating, a comprehensive health education program that will have a long term effect on all youth and be designed to effect the attitudes and behaviors. We must see behavioral changes in our students.

If schools are not already doing a comprehensive health program, though, they must begin AIDS education immediately. They cannot wait. AIDS education must be age-appropriate and developmentally appropriate for each individual in the school districts. Young children need to be reassured that AIDS, a disease they cannot control, cannot harm them if they are educated adequately. Communities need to address this issue frankly with their individuals. Communities need to know the age that their students are beginning to get pregnant, that they are beginning to be sexually active so they can begin that education before the students have already taken on these issues. We must strongly encourage abstinence, but we must also speak very frankly about the issues of control and prevention. If the students choose to be sexually active, they must be informed about the other alternatives.

The other issue is training teachers. All teachers, all school personnel must be trained in the area of AIDS and routine sanitation prevention. We must educate and involve our communities, our churches, our parents and our students.

Without support of our communities, the program will not survive.

We recommend that the Federal Government number one support research about AIDS and research about educational programs that can change our students' attitudes, behaviors and beliefs. We recommend that the Federal Government support AIDS education by building a capacity of a range of already existing organizations to meet the diverse needs of the different groups in our country. We urge that you speak out on the importance of promoting healthy lifestyles. We must stress compassion for those who are infected with the AIDS virus. We must encourage the public to volunteer, to support local school programs, and our sixth recommendation is to encourage the media to use their public forum to provide information about AIDS. In one state survey, the youth of that state said that 73 percent received their information on sex from the television. We know how important that media can be in getting the information across to our youth.

I do not need to convince you how important AIDS is. I do want you to know how important funding of AIDS education across the country must be. We cannot take a chance with our children's lives. Right now, education is our only tool. The National Association of State Boards of Education and the Centers for Disease Control are involved in this long term effort. It is a good example of how education and health agencies are working together to fight this epidemic through education.

Mr. Chairman, I would like to thank you for having the opportunity to visit with you. We stand ready to work with you in any way we can. Thank you.

CHAIRMAN WATKINS: Thank you very much, Ms. Hubbell. Dr. Boyer?

DR. BOYER: Good morning. I appreciate the opportunity to talk to you and I am very delighted to be here.

CHAIRMAN WATKINS: We have had the entire faculty, I think, of Albert Einstein.

DR. BOYER: Yes, I am a health psychologist on the faculty of Albert Einstein College of Medicine at Montefiore Medical Center. My primary interests are centered around developing scientific interventions for adolescents within the school system. That is where my energies are currently being placed.

As we know, adolescents represent a small portion of all the AIDS cases that have been reported to the Centers for Disease Control, but there is mounting evidence to indicate that the rates are doubling each year, largely due to heterosexual

intercourse. The prevalence of HIV infection among adolescents is currently unknown, however, the long and varied latency period suggest that many of the 11,000 cases of adults between the ages of 20 and 29 were infected while they were adolescents. The behaviors that place adolescents at risk for infection with HIV are common. They are a part of the normal process of adolescent development which include the early age of onset of sexual activity among some adolescents, inadequate utilization of barrier method contraceptives, the high incidence of sexually transmitted diseases among adolescents and widespread experimentation with drugs.

However, if we are to be effective in successfully preventing further viral spread among this population, we must actively and aggressively pursue methods to educate and as well train them to help prevent and reduce their risk for HIV infection. School-based education, while certainly is not the only means, represent, the most practical, feasible and cost effective method for reaching large groups of adolescents.

As we have heard today on the panel, which was eloquently stated several times, is that developmentally appropriate education should begin as early as kindergarten and has been proposed by Dr. Koop. However, when we are talking about AIDS prevention and education, it should be emphasized in early adolescence between the ages of 13 and 14, just before they are beginning to engage in those high risk taking behaviors that were mentioned before. This is also, I believe, a period when adolescents are beginning to establish adult behaviors and are perhaps more amenable to change. Therefore we cannot wait until they are in 11th or 12th grade to begin our efforts of prevention and education. Data from surveys conducted over the past three years regarding adolescent's knowledge, attitudes and beliefs about the transmission and prevention of AIDS indicate that adolescents are still limited in their knowledge, and there are tremendous gaps in the facts of what they believe is to be true. An overall finding is that many adolescents are not informed about the preventive measures to be taken during sexual intercourse. There are several studies that corroborate that misconceptions are prevalent among adolescents. Many of them believe that AIDS can be contracted through hugging, kissing or being near someone with AIDS or by wearing a sweater of someone with AIDS or by touching a doorknob that someone with AIDS has touched. They fail to recognize the fact that one could get AIDS by engaging in unprotected sexual intercourse or sharing intravenous drugs. They gloss over these facts, but focus on misconceptions which often prevent them from recognizing the behaviors they need to change. We therefore need to address this problem by targeting interventions to dispel those myths and misconceptions and change behavior.

A rather striking but not surprising finding of one

study indicate that adolescents are still engaging in high risk behaviors. It is important to note that adolescents who are at highest risk have the least knowledge. They are the ones who are not aware of ways that they can protect themselves as against HIV infection.

What we can glean from this body of research and information from other health education research is that increasing knowledge alone is simply insufficient. It is not the way to prevent or modify behaviors. Behavior change require that adolescents become active participants in their education as opposed to being passive recipients of information. Prevention programs which combine education with cognitive and behavioral skills training have been found to be effective in decreasing negative health behaviors associated with smoking, drug and alcohol use as well as sexual activity.

Cognitive and behavioral skills training appears to be a promising method for preventing or modifying behaviors that place adolescents at risk for HIV infection. The content of these programs should include, one, assertiveness and communication skills development. For example, how to communicate with sexual partners or how to negotiate the use of condoms for sexually active adolescents, or how to say no and to feel that it is appropriate to do so. It is important to give adolescents the skills to be able to communicate their feeling and to not be forced by peer pressure to engage in behaviors that they feel are not appropriate behaviors for them.

Another component of the skills training programs should include cognitive problem solving skills such as sensitivity and recognition of high risk behaviors. For example what are the behaviors that place adolescents at risk for HIV infection. It is important that they recognize that one cannot get AIDS by touching or kissing and to understand what are the real ways in which one can get AIDS. I think we should also give them skills in identifying alternative behaviors to sexual intercourse. There are other ways to express love and affection without having to engage in sexual intercourse. I think this should be explored and that should be a skill that many adolescents have.

Adolescents should also have an increased ability to think about future consequences of engaging in risky behaviors. In early adolescence, many teenagers cannot calibrate risk or cannot project into the future. They generally do not understand that something they may do today will have an impact on their health in the future. We have to give them the skills to understand and be able to realize that their behaviors will impact their future health outcome.

Another component should be appropriate decision making

skills. Adolescents must decide if and when to engage in certain behaviors or, if adolescents are sexually active, what to do to protect themselves. It is very important that they have this information. Another component is that skills training should be conducted in a group format as opposed to individual therapeutic situations. Modeling behavior among adolescents can be effective and can develop peer support for encouraging positive behaviors. Making it the norm to say no, or making it the norm to say I will not get involved in these risky behavior, I will not drink, or I will not have sex without condoms, making that the norm as opposed to engaging in what is seen as glamorous, or risky, sexy behaviors will be beneficial.

In essence, while it is important to continue efforts to increase knowledge, it is only the first step. It is imperative that we go beyond merely providing information. We must explore what are the methods by which we can prevent and modify risky behaviors. We have to go beyond merely showing films and just passing on facts. I do realize information is important, but we are now at the point where we have to take it another step further. We are at a luxurious time with adolescents in that there is still time to make an impact, while the numbers are still relatively low. AIDS has not hit adolescents as hard as it could have and still can. Therefore the time is now to get involved in developing preventive interventions.

I will not go into further detail about the content of what the interventions should include. That information is in my written testimony and therefore I will not take your time to do so now.

Before closing, I would like to take a few minutes to talk about what are some of the barriers that I perceive to developing and implementing preventive interventions. It has been stated several times today, and I will just echo the point, that, the lack of resources is the major barriers both financial and personnel. There is a need for additional monies to be allocated specifically to develop and implement new prevention and risk reduction programs. Funding agencies should take the risk of funding research interventions when they are not sure that the interventions will be effective, but we have to find out whether or not it will work and what are the means by which we can make it work. We are, essentially engaging in uncharted territory but it is very necessary.

I think there is an additional need for personnel to train and support individuals within the school systems and to assist in designing and implementing such programs and, as important, evaluating them. Evaluation is as important as designing and implementing preventive interventions.

Another barrier is the problem that comes up often in discussions with teachers and principals that I have encountered is the dilemma of adding to an already overcrowded curriculum. There is the need to explore how might AIDS curriculum fit into the overall academic curricula where they do not feel that by putting energy into providing AIDS education they will not be taking away from other important curricula which are also important. Education and prevention should not be in competition with other academic efforts. We have to find ways in which it can be incorporated. As much as math, and science, AIDS prevention is equally important. In fact, it maybe more important. We are talking about life and death.

Another potential barrier to developing and implementing these new prevention programs, is the lack of involvement of other social institutions such as parent associations, religious organizations and other community-based agencies who can have a positive impact on these programs. If we are to be successful in implementing these programs, we have to involve these groups in a very serious way. AIDS, as we know, is a very sensitive topic, particularly with regards to adolescents. Given the social and emotional issues engendered by this epidemic it is important for schools to have open dialogues and enlist the help and support of leaders from these groups and organizations.

Another barrier which is quite frustrating in our efforts to make sense of adolescents' knowledge, attitudes and behaviors is many schools forbid asking behaviors about sex and sexuality. If we are to intervene, if we are to help change and modify these behaviors, we have to understand what they are and the patterns in which they are occurring. We have to be allowed to talk about those sensitive issues and to ask what behaviors they are doing and why you are doing them. As psychologists we always want to know why and I think that this is the key into changing behaviors. Therefore we have to be allowed to ask questions and explore what the issues are.

Finally, and perhaps most important, is the need for guidance and support from our government to increase awareness and to legitimize the importance of addressing issues of sex and sexuality. We can no longer skirt around those issues but we have to see them as important and we have to take it from a very non-judgmental, non-moral perspective and I think only then we can have a positive impact on adolescents.

Thank you very much.

CHAIRMAN WATKINS: Thank you very much, Dr. Boyer. Ms. Haffner?

MS. HAFFNER: Good morning. My name is Debra Haffner. I am with the Center for Population Options, and I, too,

appreciate the opportunity to address you today. I have submitted written testimony and I also understand that you received copies of the monograph I have written on AIDS and adolescents.

My perspective is perhaps a little bit different from some of my colleagues. I am a sexuality educator and have provided sexuality education to young people for the last 15 years. We are very pleased with the amount that is happening in the states, the fact that 18 states now mandate sexuality education is a huge leap from where we were just a year ago. But one of the lessons that we have learned, is that information alone is not enough. Unfortunately, people know information but often do not act. If information alone was effective adults would always use seat belts, never drink and drive, never smoke cigarettes and weigh in the appropriate range. We know that health information alone does not necessarily impact on behavior. Dr. Walsh asked the Secretary whether teens were hearing the message, and the answer is yes and no. We know that teenagers by and large know how AIDS is transmitted. They identify that it is through sexual intercourse or through IV drug use. They also know that it is transmitted through such ways as toilet seats and mosquitoes. But perhaps what is most important is the fact that although they can identify the primary transmission routes as sex and drugs, only 15 percent of sexually active teenagers say they are changing their behavior. And less than two percent of those are doing those things that could be considered effective at preventing HIV transmission.

We have just completed a series of focus groups of inner city teenagers. What we found was that they know about AIDS, but what they know is it has nothing to do with them. If they are not gay, if they are not white, if they are not male and if they are not an adult, they will not be affected by this epidemic. We are clearly not reaching them with the message that they are vulnerable to HIV.

We have identified four primary goals of AIDS prevention programs for youth. The first is that we need to reduce the panic and the misinformation that surrounds this disease. The second is we need to help teenagers delay the onset of sexual intercourse. The average age of first intercourse in the U.S. is 16. Among inner city young people, it is 12.5. We can clearly reach societal consensus that 6th and 7th and 8th grade is too young for teens to be having sexual intercourse.

The third primary goal is that for those teenagers who are sexually active, we need to promote consistent and effective condom use. The fourth major goal is we need to reduce experimentation with drugs and prevent IV drug use among our young people.

We have identified eight key components of a successful AIDS education program for youth. The first, is that AIDS education needs to be part of a comprehensive program. The specific messages about AIDS take no more than a 15-minute lecture: how AIDS is transmitted, how AIDS is not transmitted and how to prevent transmission. However the context of AIDS education may take a lifetime. In our programs, AIDS information needs to be provided only after we have talked with students about values, decision making, peer pressure, dating, relationships, communication, sexuality, and family planning. AIDS must become part of a total package of health education, teachers must be specially trained to provide this information.

The second major component is that we need to emphasize prevention information, not biomedical information. Most curricula from around the country talk about retroviruses, transcryptase and disease symptoms. Although students may find that information interesting, it is not going to prevent them from becoming infected.

We need to be skill-based. If we want teens to "say no", we need to let them practice saying no. If we want them to talk about their decision to have sex, we need to help provide that opportunity. If we want those who are sexually active to use condoms, we need to tell them how to use them, where to get them, and most importantly help them practice how talking about condoms with a partner.

The third key element is that we need to emphasize behaviors in talking to young people, not groups. The teenagers that I have talked to continue to distance themselves from this disease, because "it happens to other people". We need to emphasize that it is behaviors that put you at risk, not your group identity. The fourth component is that there need to be ample sessions. Sexuality educators report that schools are inviting them to give a 45-minute lecture on AIDS, so the school can say it has "done AIDS". AIDS education is not an inoculation. Once is not enough. Teens need to hear this information consistently and effectively. The unfortunate fact of life in this country is that health education often stops in the 10th grade. We give teens information once and our obligation is over. We need to make sure teens hear information repeatedly, in a variety of settings and by a variety of messenger.

A fifth component is to develop peer mediated programs. We are not listening to the young people of America tell us what they need to know about AIDS, and I am very glad you are having some young people talk to you this afternoon. Some of the most effective health interventions for young people have been those where the young people have taken the responsibility themselves for transmitting the message. One of the leading example are

the Students Against Drunk Driving chapters, in which young people have actually changed the student norms around drinking and driving.

The question was asked this morning, are we giving kids conflicting messages. What is conflicting is that what we are telling them in school and what the government tells them conflicts with what they hear in the hall. We say "just say no". They say "everybody is doing it", and that is often the behavior that makes them more socially acceptable. I would challenge our culture to come to the same agreement that we have about young people and drinking. We do not want our young people to consume alcohol. We say to our children, "we do not want you to drink, but if you are going to drink do not get behind the wheel of a car because we care about you. Call us and we will give you a ride home".

I think that this must be the same message with sex. We can say "We do not want you to have sexual intercourse now. But, If you are going to have sex, protect yourself because we care about you. Do not kill yourself".

The sixth component is that AIDS education must be based on values. There is a myth that what we can do in our schools can be value-free.

We, too, believe that abstinence is the best method of AIDS prevention, and that we need to help get that message out. We also believe that long term committed monogamy in a heterosexual marriage is one effective prevention strategy. Monogamy to many teenagers is some place from three weeks to three months. That is not the kind of monogamy the Secretary of Education is talking about. Young people choose relationships for love, but often these relationships are short-term.

I believe that a critical value, and it is a value that I hope this Commission adopts, is that it is immoral and unconscionable to say to the young people of America, "just say no or die". Instead, we have to say to teens, "we will provide you with the information to save your lives".

A seventh key component is that AIDS education must be sex-positive. We have gone from talking about the joy of sex to talking about the dangers of sex. I believe that we may be raising, because of the AIDS epidemic, a generation of sexually dysfunctional adults who are learning that sex kills. We need to tell teens that sex is wonderful, but that it needs to be practiced responsibly. We need to recognize that among the young people of America, there is a diversity of sexual behaviors. In particular, not all young people are heterosexual. There are gay young people in our schools, and they need special support and

services.

Finally, we need our message to be empowering. Many of the programs that I have looked at are trying to scare our children; they believe that if we just scare them enough, their behavior will change. Decades of health education interventions tell us that that is not going to work. What a few young people have told me is that AIDS is now inevitable. "It is going to happen, so why try to protect ourselves?" The message, then, needs to be an empowering one. It needs to say to young people, "everyone who is not currently infected never has to be. We now know the information that will protect you. The 53,000 people who now have AIDS did not have a chance because we did not know what behaviors they needed to adopt. We now understand transmission. You never have to become ill with this virus because you can make the decisions to adopt safe behaviors".

My plea to you all is that you not just mandate AIDS education in your report but that you call for effective education, education that gives our young people the message that we care enough about them to have the political will to help them develop the skills needed to protect their lives. Thank you.

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

CHAIRMAN WATKINS: We will start the questioning of this panel with Ms. Gebbie.

MS. GEBBIE: My apologies to a couple of the witnesses that I did not get a chance to hear you. I have looked through your written remarks. I think I will start with a question to Dr. Boyer and Ms. Haffner. I want to pick up again on this issue of messages that sound ambivalent, that say "Do not do it, but if you do it, here is the safe way". I think a lot of folks have trouble sorting that out as to whether that is not somehow a covert message that it is okay to do it. The front part is just a sham, and they do not quite understand how we can be doing both. I tend to agree. I do not want to have a child who made what I think is a wrong first decision to end up dead or with some other problem because of what could have been safer second decisions. Can you talk more about how you would do that kind of education without sounding wishy-washy, ambivalent or somehow confusing to the kids?

DR. BOYER: It is evident by the data that we see that adolescents are engaging in risky behaviors. They are having sexual intercourse, they are having it at an early age. They are becoming pregnant at early ages. Sexually transmitted diseases are highest among adolescents to indicate that they are engaging in unprotected sexual intercourse, and that, we can point the evidence to them and say this is what is happening, but you do not want to be in that same position. They are thinking

individuals. It is not like their brains are made of mush. They are thinking individuals. All we can do is provide the information for them and reduce their anxieties about these different values and different things that they are hearing and hopefully they will make the best choice for themselves. I think that we have to be frank and honest with them although this is difficult. It requires some thought, and they must think before acting. That is one way of making it a little easier in helping to make sense out of it without sounding like we are giving them double messages.

MS. HAFFNER: I think part of it is what is age and developmentally appropriate. The "just say no" programs that have been effective have been the ones that are aimed at the sixth, seventh and eighth graders who, before they are sexually active. At this point we can be successful with positive reinforcement about saying no and resisting peer pressure. My experience as a lecturer in schools is that when I tell a class of juniors, 11th graders, that half of them are sexually active, but half of them are not, there are always sighs of relief. Teens believe that "everybody is doing it", even though studies tell us that not everybody is doing it. I think we have to look at the fact that young people in our classrooms have a range of sexual experiences. Some of them are upset, that they are 16 and never been kissed; some of them are upset that they are 16 and are still virgins, and some of them are upset that they are 16 and not mothers yet. There is a wide range in our classrooms and that we need to provide education that encompasses all these young people.

MS. GEBBIE: Thank you. My other question is to the people that represent the national associations related to schools. The process of getting the executive board or the top level of a national association together and applying for a grant and getting a position paper on a subject like this seems to me to be relatively simpler than getting 5,000 local school districts together to do something. Your statements are very articulate and very supportive of some of the things that I think this Commission is interested in doing, but I suspect, as I know from school districts in my own state, there are a lot of school districts who might read these sentences and say, my gosh, what is going on here? How did the PTA get in favor of this radical stuff or something like that? Can you talk a little bit about that process of translating through the nation to some very independent local situations the kind of thing that we are talking about here and that you seem to be supporting in your statements? How does that work? What kind of mechanisms do you have? What kind of credibility you have? How readily are you turned to? What impact can you have? How does that work at the local level?

MS. UNGAR: Since you mentioned the PTA, let me tell

you how we work. It is a two-pronged effort. Number one, most of our position statements and programmatic thrusts come about through the 26,000 to 30,000 local PTA's that incorporate our 6.2 million members. They have representatives, in a pyramid fashion that go up to their state level. They meet annually to adopt resolutions from the several states. That is one way in which we arrive at position statements. The national board is composed of the state presidents of all 50 states, the District of Columbia, and those parents whose children are in the Department of Defense schools around the world. So we have 52 state presidents and we have widely elected officers like myself. They will take the input, if you will, from all of that leadership and grass roots concerns. We will adopt position statements that we feel are reflective of, representative of, or in some way that will be acceptable to, our own constituencies. So we adopt our positions and arrive at those positions in that fashion.

The people who have come to those conventions have written and debated those resolutions, and have elected us to speak for them. We have very close contact with them. As a volunteer, I travelled last year 82,000 air miles so that I could go out and speak to local unit members and, more importantly, so I could hear from local unit parents, teachers, administrators, and others who the A stands for in Parent-Teacher Association.

I feel very comfortable, as does our leadership, that this is something that the majority of parents in this country are asking for. I also want you to know that our association, unfortunately for us, does not represent every single parent in the United States. We feel that the information that we have should be made available to any parent, indeed any community, that wants it. You do not have to be a parent to be a member of PTA. You just have to care about kids.

The other thing is that they already know, because of what we have told them in our dialogue, that it was in 1898, one year after this association was formed at the national level, that they adopted a resolution which said that they believed that there should be teaching about sexual activity before puberty. Therefore, we do not come to this lightly.

MS. GEBBIE: That is an interesting fact. Thank you.

MR. HOWE: From the standpoint of representing local school boards, we are the elected or appointed representative of the community who sit as the policy makers, on the national level. We have to give an example and to do so in a way that it is a positive reinforcing type of situation. I think that what Ms. Ungar has said is education is a key factor, not only as to what we are going to be doing in the schools, but to educate those of us who are in policy making or the administrative capacity to be prepared to do it.

Consistent with that, the National School Boards Association has issued a number of publications. One, I think you have, is AIDS and the Public Schools. This is not a recent publication. This is about two years old if I am not mistaken. We have had the Surgeon General of the United States address our assembly, our convention, which is the largest convention of school board policy makers in the United States. Our forthcoming convention in New Orleans which is coming up at the end of this month will have a very involved panel discussing AIDS education. What you as a local school board member should be doing relative to an AIDS program within your curriculum within your community will be discussed.

So we are trying to not only do as we say, we are trying to do as we do and to get that example across. I think each of the organizations on a national level has taken a very positive thrust and positive approach. We need resources; we need more information; we need people to understand; we need good communication as to what the real situation is and what the real world is out there there. I come from Illinois, where we have had, I think, unfortunately in some situations some misinformation. But we have also had a number of school districts that have met this crisis head on in a positive way, have garnered support of their community and garnered the understanding of their community by being prepared and having good policies in place.

MS. GEBBIE: Thank you.

CHAIRMAN WATKINS: Dr. Lilly?

DR. LILLY:: I do not have much in the way of questions. I just want to thank you for cheering me up a little bit after the initial panel this morning. I have the feeling that some of you are perfectly prepared to suspect that these young people should, at some point, be taught that there is a word penis rather than any of a number of other words that have been learned and that one can use a condom and be unsafe as opposed to immoral, and that you might not even drop dead if the words anal intercourse were mentioned in your presence.

There are still hard communities that are against, at least I am told this, that are against AIDS education, that are against health education, that are against sex education. Since all of you believe strongly in it, what do you think should be done about it because I think it is rather widely believed that communities should have a good bit of say in what goes on in their communities.

MR. HOWE: Let me take a crack at that again from a policy making point of view. I think one of the difficulties

that we face is that if we are going to look at this as an educational issue, then let us look at it as an educational issue, not a political issue. If we look at it in the way that this is something that is vital to the welfare of the people who reside in this country and the citizenry of this country, then we should go at it educationally. A person's politics or other views should not necessarily cloud our opportunity to provide truthful, factual, informative materials in the classroom setting as is appropriate for the level of the age of the child or as it may be needed within the community. Yes, you are correct. There are communities which probably do have strong resistance to anything dealing with sex.

We are dealing with something here which hits two issues that are very strong -- personal issues -- sex and drugs. When we start talking about those behaviors we know and we can guarantee we are going to have some kind of reaction from the segments of our community that are not going to be in favor of going forward with the program. That is why we have to set a good example; that is why we have to set the parameters of going forward with this aggressively, forthrightly and saying, "Yes, you may have disagreement, but once in a while we do have to make the hard decisions and we ought to make the decision in favor of life."

MS. HUBBELL I might just speak a moment to that same issue, having come from a state that has just recently mandated that every district must provide AIDS education. We represent a lot of very small, rural districts as well as urban city districts. It was the rural, small districts who were saying the state must take the leadership and must mandate all districts to teach AIDS education, because their public were against the issue.

But we found once we educated our publics of that fact that this is a life and death issue, I believe they turned around. I feel very positively that every school district will do more than show a film in our state or just present a pamphlet. They know that they must do it, but it was not that way six or eight months ago. It was because we educated the individuals in those local communities to the fact that it is an educational matter, it is a health matter and we must work together so from a personal standpoint, I do believe it can be done, but it is not easy and we did take that strong leadership to tell them that it must happen.

DR. LILLY:: I am very encouraged by your optimism.

MS. HUBBELL I hope so. Thank you.

CHAIRMAN WATKINS: Ms. Pullen? Dr. Lee?

DR. LEE: First of all, can you tell me what the Center for Population Options is? What do you do? What is the story there?

MS. HAFFNER: We are a national organization founded in 1980 to promote life options for young people. Our primary goal when we began was the prevention of unintended teenage child bearing, premature teenage child bearing. We see that in a very broad spectrum: we believe that in order to prevent teenage child bearing, we need to make sure that young people know that they have adequate life options, and that includes quality education, quality employment opportunities, adequate housing, as well as family life education and services.

DR. LEE: Nobody else does this? Where, why did you create this organization?

MS. HAFFNER: We felt that there were many organizations dealing with issues related to family planning, and but that very few groups were concentrating on the very special needs of adolescents. As a national organization, we primarily work with many of the groups at this table. I work with a partnership program of 60 national organizations ranging from NASBE to the Junior League to the Boy Scouts to the America Camping Association who look to CPO for leadership and guidance on development of family life, sexuality education, teen pregnancy prevention and now AIDS prevention programs.

DR. LEE: I want to compliment you on your bibliography in here. It is quite a nice one. I think it is going to be helpful to us. One of the things that upsets me personally and it must be one of your major problems, is that schools in this country seem to be increasingly parent substitutes. I mean, I was told by my wife to tell my son about the facts of life when he was 10 or 12 and I made a pass at it, but I do not know why, why is all of this loaded on the schools?

We have a Catch-22 here in AIDS. The people who are running around really getting AIDS are not the people who are paying attention to you. The very much higher percentage of AIDS is in the people who have drug habits, who have dropped out and are into prostitution, who come from these terrible families and who the school system just cannot address. I mean, your best students are not your problems. I mean, anybody who is sitting around listening to Dr. Boyer and Albert Einstein, I mean, I think is in the clear. So are your organizations reaching out and grabbing people that are not coming to your schools? Are you approaching the Catch-22 that we have here? Education is like mother's milk. We love it, but there are a lot of people who are not in your system. Are you reaching to them in some way?

MS.HUBBELL: In comprehensive health education programs, we are reaching the youth and we are reaching the students in fifth and sixth and seventh and eighth grades before they choose to possibly not continue their high school education. As a national association it is our goal in the next three to five years to have educated 100 percent of the youth that are still in school and that are of the younger age groups. So in a comprehensive health education program, when we think of that as AIDS education, in the coming three to five years, we should have educated the youth that will be the teenagers and the young adults in five years. Currently, not all of those young adults are being educated.

The other portion of that is the fact that we need to tie into community groups so we can get the students that are dropouts and are currently not in school. We are not hitting those 15-, 16-, 17-, 18-year-old students who are not currently attending a public or private institution and we must also talk to those. We have talked a lot about sexual intercourse. We have not talked about the IV drug users and that is another very large group that are difficult to reach because they are not always rational in their decision making. It is our goal as a national association and as a state association, too, in the next three to five years, to have educated all youth, but also to work with community groups who those youth are tying into, to put our brochures in the blood banks and the plasma centers so that they will pick them up and begin to be educated. It is a very difficult issue to address. I agree.

MR. HOWE: Unfortunately, I think it has just been our lot in life in that the schools have been looked upon, in the six hours we have a child 180 days a year, as solving all the problems of society through education. We cannot and we know that and what we have to do is play our part in the responsibility here. I think that is what we are all saying, but there are others who are involved: the parents and the teachers. Members of the community are involved and should be involved. The churches, other social agencies have to take their responsibility, but unfortunately many times that responsibility is shifted to the schools. We bear the brunt. It is not our fault but we get the blame. It is not the child's fault. The child gets the blame. We need to back away from that and look at what our mission really is in providing education, and in doing that I think it is very important that we address some of the issues that we have talked about here this morning as part of the total educational program.

MS. UNGAR: I guess my role in all of this as the only non-professional seated at this table, is that we recognize preaching to the choir. Very frequently in our own PTA meetings, only those who are already very well informed are there. We

recognize that also societally, because of the changing demographics and the nature of our society. We recognize that we, as an association, PTA, can no longer be the afternoon groups, the study groups for parents. We have to find new ways, strategies, to reach out to not only those members who are not there, present, physically, at our meetings, but also to reach out and include others who, unhappily, but in all candor have been traditionally underrepresented in associations. Ours is the fifth largest association of any sort in the United States. I think we are exceeded only by the AARP and the AAA, two of the four that I know of, and some of us are members of all three, who are still in PTA.

But the most important thing is that we recognize that we have to reach out and to include others who would not ordinarily come to us so we are doing consciously just that. We are doing it through coordination and collaboration with groups that traditionally we have not collaborated with. We are going to different sites and are not saying come to the school in the afternoon or evening, recognizing that many of those parents - and it is not just the poor and it is not just the minorities - are now unable to go to the traditional kinds of meetings to get educated. We have to find out another way of reaching them. We are experimenting with that. We are going to where they are and where the need is in trying to include all of it. We are all partners in this, and we ought to be cooperating and collaborating with each other.

DR. LEE: I want to hear from Dr. Boyer and also Ms. Haffner.

DR. BOYER: My sense is that it has to be a dual pronged approach. While the school, I think, represents only one part of that effort. It is an important effort even though the highest risk kids are not in the schools, we still have to teach them prevention. There is still a small percentage of kids in school that our research shows is representative of national statistics. That one percent of the individuals in the schools we surveyed were IV drug users and that kids in schools are engaging in high risk behaviors, and having unprotected sex, so there is a role for the school to educate them as well. I think that is where our prevention efforts should be targeted.

When we talk about community-based efforts, we are talking about remedying a situation that is already bad. You have the kids who are at highest risk on the streets, who are prostituting. That is another approach, and I see the school as only one part of the effort but it has a real impact or the potential for impacting on preventing adolescents who may be exposed to HIV infection.

On a community-based level, we have to deal with

changing situations that has nothing to do with HIV except that these kids are homeless, they are not educated, they are your disenfranchised. I think it takes a different approach if we are going to be effective in reaching all adolescents, it has to happen on both levels.

MS. HAFFNER: Dr. Lee, I just wanted to add something, we believe, and I know most people at this table believe that parents are the primary sexuality educators of their children. We do not do this through that one "talk", that big talk, but rather through our behaviors: how we treat our young people from the time they tell us in the delivery room it is a boy or it is a girl, whether we teach our children the correct names of their body, whether we, in the bath say "this is your tummy and this is your knee" and we forget to name some parts of their body at all. As they watch our relationships within our home, they learn about sexuality.

Unfortunately, 80 percent of the parents of this country, say that they know it is their primary responsibility, but they are not comfortable. They do not feel they have the information. Their parents did not talk to them. What I think the schools can do, and community agencies such as the Y, the Red Cross, the Girl Scouts and Boy Scouts can do is to provide supplemental information as well as providing programs for parents to come in and learn the information so that they can feel more comfortable educating their children at home.

DR. LEE: You know, I am a very liberal person myself. I do not care what goes on in school. If the professionals tell me it is worthwhile, and the sexuality is good to teach, fine. But I have personally met some "sex educators" that I would not send my kids off to say, well, good luck, pal, and when you come back I will give you a Coca Cola and I hope you get through it. It is a very, I think in many ways, it is a very difficult thing to be dumping on the schools. But I realize that it has to be done. I understand that.

MR. TOLSMA: If I might also respond on the youth out of school question I think part of what you say is true. There are a lot of kids out there with a lot of problems, and can we teach them something that is going to stick and make up for all the problems that they face in their lives? Amongst the national organizations that are funded there are several that focus on the needs of young people out of school. One of the minority organizations, for example, has an Hispanic out-of-youth focus. They are trying to reach this particular population. Another funded organization, the National Network of Runaway and Youth Services, comprises 300 youths serving organizations. We are working through that network to reach youths out of school.

This is not to say that many of these organizations

that are school-focused and school-based do not recognize that youth out-of-school continue to be a responsibility, and I have seen local school systems do very useful programs, schools without walls and this sort of thing, in an effort to reach that very difficult population. We are not without some ways to carry out these kinds of educational activities, even for that difficult to reach population.

CHAIRMAN WATKINS: I would have to say, Mr. Tolsma, that the impression we get as we move around the country is that education is in the schools. The perception by most American people is that it is in the schools. Yes, we know we have one million out of four million that reach 18 year olds each year that are not in the schools. They are in the high risk group. We know about the growing numbers of minorities in the country, the significant growth in the Hispanic community that will exceed the black demographics by the turn of the century. It will give a whole new dimension to what might be happening so I would like to know if this panel feels that somehow we have to kind of define an educational concept in dealing with the AIDS epidemic, to make sure we focus on all elements, out of school, in school, out of the workplace, in the workplace, health care providers education, all very much a part of the picture. I do not think that the education needs of this epidemic has been well articulated yet, let alone everything else that we needed to deal with regarding to this epidemic.

I have given a number of presentations to the White House symposium on education partnerships for two consecutive years, with a thousand educators there, and I asked the questions: "How many health promotion czars are there in the room?" "How many Secretaries of Health or their equivalents or representatives from the states are here?" The answer was "None". Now, it seems to me that education includes health education as curricular and not extracurricular any more. When are we going to get to that point? What are we doing to try to raise the understanding of what we are talking about in education on this issue as something that is more comprehensive along the lines that were presented by a variety of panelists right here in this particular panel?

I think CDC cannot be the sole entity for all of this. It is so large, it engulfs us all. There has to be much more emphasis on the variety of educational strategies we are dealing with because in the mind of one beholder, it is in the school. In the mind of others it is totally out of school.

MR. TOLSMA: You are right, and we have got 48 million kids in school, another million and a half not in school, and that is a big and elusive sort of thing to wrap your mind around. What I was trying to say was that we do not want to leave out of our equation the young people at risk right now but will want to

find and use the channels as best as they are, to get to them. But I think there is a vision. It is a vision of the year 2000. The class of the year 2000 starts first grade in about six months; we have about six months left is one way to look at it. I would like to see that generation be a smoke-free, drug-free and an AIDS-free group of young people. To do that means to adopt in our nation the kind of strategy you have heard described here, and as Manya Ungar pointed out, we have these young people in our schools, even if they are someday going to be dropouts, for a number of years. In too many schools, they are not at present receiving the kind of program that they ought to get.

Yes, I understand the barriers that the school administrator faces. The curriculum is like, it is like a case of Coca Cola which has 24 cans in a case. If you want to put another can in, you have got to take a can out, and schools have to find a way to fit into the 180 days, six hours a day the sorts of things that everybody wants. Comprehensive health education, including effective education about AIDS, has to become a higher national priority; it has to become a higher local priority. That is to say, we need to provide the leadership. Your Commission can provide that leadership from the national level. These organizations can provide that leadership from the national level. That document that was shown to you is called the leadership report. Leadership at the national level is very important, but also leadership is needed from the grass roots, from organizations like the PTA that are out there in the grass roots saying that we have to raise our concern about health of young people to a high level and make a greater commitment to it in our community.

CHAIRMAN WATKINS: I agree with you 100 percent, but as you know, the Youth 2000 project that is going on in the Department of Health and Human Services, it includes the Department of Labor, National Alliance of Business, members of the National Assembly and the National Collaboration for Youth. Fourteen top youth organizations are represented here today. One group that will not get in the Youth 2000 effort is the Department of Education. It will not join it. That seems to me that we are at that point where we simply have to pull it all together on this educational concept because when the rhetoric is passed around the nation it results in confusion. One person is talking about one set of issues, another is talking about a different world. I am just asking the panel to comment on whether or not it is not time to clean up what we are talking about in education, in more clear terms.

MR. HOWE: I think the key to the answer here is that one of the reasons that the Department of Education was created in the first place was to provide a focus at the federal level as to educational programs, and I think it will be extremely beneficial. We have been talking about mixed messages. I think

we need to have one voice speak on the educational issue relative to AIDS education from the federal perspective. That can be done by leadership; that can be done by example; that can be done through solid programs which support the local level, support the state level, get down to the grass roots, get down into the classroom, get down into the community because it is going to be a big project. The schools alone cannot be responsible for all education. A lot of education takes place outside of the schoolhouse, and it is our need to correct some of that education that takes place outside of the schoolhouse. I think that becomes an imperative here.

MS. UNGAR: The worst that can happen to me is that I have to go home and do the dishes so let me say something. From my personal perspective and as somebody who has had frustration in the last eight years of having to explain to our membership, I foundd frequently that what the U.S. Department of Education has been saying is not necessarily what the state Departments of Education and local boards of education would like to do. There has been a different ideology in the Department of Education.

I speak from this not just because I am currently President. For four years, I served as the sole registered lobbyist, if you will, a little "one", unpaid lobbyist, as Vice President of Legislative Activities, for National PTA, and during that period of time we found ourselves going in to testify at the request of various committees on where we thought the Federal Government and the state and local governments ought to be going in regard to education. .We thought we would go in there and find ourselves united. Our problems were not with the National Associations of Administrators or School Boards of Principals or State Boards of Education. All of us, separately and together, seemed to be able to come to some sort of consensus. When we came in, we discovered that the chief opponent of that particular issue about the need for education, the need to fund it, the need to provide seed money, the need to provide that leadership, guidance and the underpinning of moral support, if not resource in greenbacks, was the Department of Education representative. I do not know why.

But I really think that that is the truth as I have seen it, and it has been a big bother to us, and we represent all kinds of people. We are, I suppose, a microcosm of the United States. We do not have any litmus test for membership. We do not ask you what political party you are, we do not even ask you to be a parent to be a part of PTA so I would guess that we are very reflective of all the political parties in this country, all socioeconomic levels and I would hope sexes, ages and religions in my association and all or at least some of us seem to have felt at some point, that there, for some reason or other, has not been that kind of support. There has been a lot of rhetoric. There has been a lot of saying everybody ought to hunker down,

tighten their belt, be good, say no, but there has not been the resources and the commitment to put all of those things in practice.

MS.HUBBELL: I might just add one other comment very similar to that in the fact that the national education associations such as NASBE, and all the others represented here, seem to be working together, very cooperatively in this agreement and along with the health agencies. It is my goal that the health agencies who have the knowledge, and the expertise, on the issue, and the educators who have the knowledge and the expertise on how to give that information to the students and how best to put it forward in the curriculum decisions of what is appropriate at what age level so the two organizations, the education organizations and the health organizations must work together to make this successful from the national level clear down to the local level.

We are finding that as in the National Association of School Boards, and the National Association of State Boards of Education, work with CDC on these grants, and we also find it at the local level, a local school board working with their local health nurse to give that information to the students, to the parents and to the communities so it must be a cooperative effort and it must start, I think, at the top and the bottom and work together to be a continual program to educate our youth. I do not have the answer either but I do believe that most national associations both health and education are trying very hard to cooperate and to communicate with the public.

CHAIRMAN WATKINS: Dr. Crenshaw?

DR. CRENSHAW: I want to especially thank Ms. Haffner for her comments about putting all the information to our teenagers about AIDS infection in a positive context. It is really important that we not give the message that sex is death, and we can give the message that sex is health if good judgment is a part of our choices. The other point that you raised that I think is really valuable and would be important to be more widely understood is that when we are talking about teaching sex with or without values, I personally, with all the sex educators I have dealt with, have never seen anybody teach sex without some values.

People who say they are neutral are mostly people with undeclared values and they may not even realize what the bias they are coming from is, but I think this can be clarified. What we need to come to terms with as a society is what are the best values to preserve health without horribly offending communities that could not cope so that we, again, can come to more common ground. I have seen more and more common ground achieved because we are, as a society, all on the same wave length right now that

we must have AIDS prevention education in the school system. There is more debate about sex education, but it is becoming more and more clear. You cannot have one without the other, and it can be in the context of health, of biology. One needs to start very early but be age-appropriate. I think all of these are tremendous steps forward.

I would say that one of the real obstacles that we have not confronted yet is that when it comes to the nature of the education, exactly what is taught, there is great disagreement because there are two camps. One fears that information is synonymous with permission and it is going to cause the very behavior you are trying to prevent. The other camp believes that information and judgment can prevent behaviors and can engender responsible behavior. One of the things I would really encourage is more dialogue on this point because I have seen model programs where parents and communities and teachers have gotten together and, once they have sorted these things out, they really worked hard in the best interest of our kids.

Even though I did not hear it quite so directly, the spirit I got of what you were saying is that we tend to underestimate our adolescents, and there is a lot more that is possible. I mean, a lot of times people kind of sell them short and do not try to achieve certain things. You were talking about the extent of sexually transmitted diseases in the population, I agree with Dr. Lee that homeless people are very, very hard to reach. Your programs do not always access them. I think it is really important not to become oblivious to the fact that these sexually transmitted diseases could be AIDS five years from now and are just very, very rampant through the populations that you are addressing directly.

The one other thing I would like to comment on, and then I would like some comments from you, is that somebody mentioned that education is not enough. Information is not enough. It does not engender the behavior change you are necessarily looking for. One of the things I have seen overlooked is the importance of rehearsal behavior -- how to implement, what to say to discourage sexual activity, the actual words. If you do not give the kids the words, they do not often put the concept into practice. What techniques are available that you are aware of that may move forward in that arena of making the translation between information and the social skills to put that information into practice.

The last point I would make is probably the only area where we have disagreement. I was quite mad that you did not have condoms for pregnancy prevention. I have no discomfort with them. I do not have the confidence in them for AIDS prevention that many people do. With pregnancy prevention, if they fail, you gain a life even if you do not want it. With AIDS

prevention, if it fails, you lose your own, so to me the jury is still out. I am worried about giving teenagers or adults a dose of a false sense of security where we have to retroactively revise our perspective. I hope that we are just really thoughtful and careful in putting the recommendations in perspective so that we do not oversimplify the solution. But in any event, particularly with rehearsal behavior, I would be really interested to know what is going on and what you are suggesting.

DR. BOYER: I would like to respond to that. I agree with you 100 percent, Dr. Crenshaw. I think that that is the point at which we are now, we have to explore ways in which we can prevent those behaviors and as I mentioned in both my written and oral testimony, that there is a need for communication skills training. We have to train adolescents as you are suggesting, and I think we have to start on a small level to be sure that what we are reporting as happening is in fact, effective. That is the point I would like to make, that we have to have support for pilot projects to do more focus groups and more training of skills and to empower adolescents with this information and with the confidence that they can effect change in their lives and that they can make appropriate decisions.

I think that there has been very little work done to date. I do not know of any research in which that has been done with adolescents. We have some sense from the gay community that prevention and education has been effective. We know from other areas of research such as smoking and drug abuse that skills training have been effective. I do not know of any efforts to date of which that has been applied to AIDS education as well as sex education. I think that is where our energies should be at this point, in exploring those mechanisms by which we can implement that, and I must say that is where our energies are being focused in the Adolescent AIDS Program at Montifiore Medical Center and, in fact, we will be implementing very soon a pilot project to explore this and I would like to encourage funding agencies to take the chance on those pilot projects and to give us opportunities as researchers to find effective ways in which we can make that happen on a larger scale, both within the school system as well as in the communities around them.

DR. CRENSHAW: I sure agree with you, and I hope we can do something to help in that.

MS. HAFFNER: There is some body of literature on teenage pregnancy that looks at some of the interventions. For example, the Emory program, which both Secretary Bennett and I applaud, for the seventh and eighth graders has shown that through having teens practice saying no, and helping them identify the pressure they feel, there may be a delay in the onset of sexual intercourse.

The Girls Clubs have also an excellent evaluation of their programs. At the Center for Population Options, we have just started another pilot project. We are starting "Teens for AIDS Prevention chapters in two D.C. schools. To help teens to take responsibility for educating each others, to help to stop the spread of HIV in their schools. In one school, we had 100 teens apply for 12 positions, and that was a very positive affirmation that young people do want to get involved.

I would like to tell an anecdote, which shows that effective AIDS education will be very difficult. I had done about six hours of skill practice with a group of teens. We had really practiced saying no, communicating, talking about condoms, decision making, etc. At the end of it, I turned to one 17-year-old boy and said, "Let us say you are at home. You are alone. There is no one there. You are with a young woman. She is coming on to you. You have no condoms. What are you going to do?" He said," Mrs. Haffner, how pretty is she?" I was struck then that this is going to be very tough. Even with all of the good exercises, it boiled down to an immediate need. And that is why I think it is so important we talk to teens and ask them what will make a difference to them.

DR. BOYER: If I may, I would like to add another point that it is not only a matter of skills training. I think we have to also help them to problem solve, to find ways in which they can work through a problem as opposed to just practicing a particular behavior or an answer to a behavior. I think it takes more. It has to happen on a cognitive level as well as building their self esteem, to build their self confidence that they can, in fact, have an impact on their behavior, and that they are in control of the behaviors that they engage in. So it is more than just practicing positive outcomes.

DR. CRENSHAW: I agree. I think one thing that needs to be underscored is that while there is an awful lot of criticism aimed at sex education programs for their effectiveness in preventing pregnancy and a variety of other reasons, one of the things that is not very well appreciated is the obstacles faced by the educators beyond just political turmoil. The fact that they do not have money for texts and usually have to work from syllabi, the fact that because of the pressures, they are not able to respond to questions without fear of being fired or great turmoil and significant. If we try to teach history or English under these circumstances, nobody would say English education does not work or history education does not work. We would change our system so it would become more effective I would be the first to admit that sex education programs have not been of consistent quality and good and they need massive improvements, but we need the support of parents and society and a great deal more funding in order to achieve that.

CHAIRMAN WATKINS: Dr. Walsh?

DR. WALSH: I am encouraged by the fact that we are all trying. That is a good beginning. I think one of the real problems that we are facing is that the most horrible phrase that ever hit society in this battle is the phrase "safe sex." That scared the living daylights out of parents because they envisioned all of you as sitting up in front of the classroom and teaching their kids that promiscuity is fine and here is how to do it. We are going to show you how to do it so get out there and do it. Despite the modifications that have been attempted on that original phrase once it was let loose, at least in most of my experience, everybody still harps on that phrase. That is why I like so much the concept that you have of including your efforts in a program of health education - even getting away from the phrase sex education.

The very same parents that Ms. Haffner refers to, the 80 percent that do not want to discuss sex with their children, are somehow repelled by the whole concept of sex education, primarily because they do not understand it. I think one of the great things that the PTA could be doing, however, perhaps with the cooperation of the schools, is to concentrate a good bit of time on the parents to give a health education course and curriculum to the parents so they will let the children be exposed to it. While I feel the parent has a basic responsibility, I do not think that we can in any way denigrate what the school can do. It is in that six hour day that Mr. Howe speaks of that the student is exposed to peer pressure. That is where he gets the pressure from his classmates that he is not one of the boys or not one of the girls if he is not doing things that everyone else is theoretically indulging in, even if most of the time it is in their imagination.

There are two things that I would like to ask, you. Ms. Hubbell pointed out that 18 states now have so-called AIDS education. In health education, does this mean that sex education per se is included in all the 18 states' curriculums? I cannot believe that because certainly I hate the thought of AIDS education as something that has to set by itself as you have all spoken to the problem of teenage pregnancy, other sexually transmitted diseases, just plain old fashioned sexual behavior, sexual habits, respect for one another - all of these things are all part of health education. I hate the thought of our pinpointing AIDS education because this will not get public support by the year 2000.

MS.HUBBELL: I fully agree. Of the 18 states that have mandated AIDS education, I cannot tell you how many of those are comprehensive health education programs, but of the 50 states, many of those have health education programs in their

schools. There is a difference in the state mandating it and requiring it and the local district providing it. In our situation, we chose, as I said, a comprehensive health education program, including the teaching of sexually transmitted diseases, including AIDS is how our statement is written, and we also, even in our funding from the state government, are requesting health education/AIDS education funding because we know that that is politically saleable.

Our local school boards were asked to do a blueprint of what is actually already going on in their schools in the area of comprehensive health education and then where information was lacking to fill in the gaps and to include the AIDS education as a portion of the sex education K through 12. I do not have any exact statistics and will be glad to get those for you on how many states are doing health education programs. Many more are doing it than the 18 that are required in the sex education/AIDS education but it is not happening in every school, and it needs to happen in every school, accredited public and private throughout the country, so it is a beginning and I fully agree with you.

DR. WALSH: I agree with that. Another concern that I have heard expressed, and I do not know the validity of it is that many parents who may be less liberal than my friend Burt Lee over there are concerned of how these courses are taught. They envision wild-eyed liberals teaching all sorts of awful things to their children. Is it customary in the school systems to allow representatives of PTA to sit in a room? You see how far back it was when I went to school. That was never done. Is that done to allay those anxieties and those fears because if you do not convince the parents, we are never going to get them.

MR. HOWE: I could not agree with you more, and I think that one of the things we very strongly suggest to the local boards of education is that as they are developing these curricula, they involve parents, they involve health professionals, they involve doctors in their community, pediatricians and the rest so that we develop a program that is going to be saleable to parents - they are not going to withdraw their child's participation in that program which many states allow a parent to do. Many states allow a parent to remove a child from a program even though it may be mandated or otherwise, if that parent has an objection to that particular program. That parent may remove the child. We do this to have a program that does pass muster with the community, that does meet the needs of a child at an appropriate age, and yes, we encourage having parents come to the schools and see what we are doing so that they feel better about it. They are proprietary in what is going on. One of the hard parts that we have now in our communities is that only 22 percent of the voters in a community now reflect the parents in that community.

DR. WALSH: Yes, that is right.

MS. UNGAR: I would like to add that not only have we been making the effort to try and educate the parents, indeed for the last 10 years in cooperation with the March of Dimes, we have been providing and are continuing something called Parenting Seminars in which we are helping parents to get over that discomfort in trying to communicate what they know they should be communicating but as you rightly point out, 80 percent just do not know how or are afraid to. I think the commitment to that is that more than 80 percent of the parents have said they would like the schools to do the job for them.

The other thing that I think is very interesting and Jonathon Howe knows, is that if the school boards do not invite the parents into this process, the PTA will also communicate to them the skills of how they can become a part of that shared decision making.

DR. WALSH: A third question that I have is I believe the Secretary of Education said this morning, and I think some of you pointed out today that there has been considerable cooperation between the Department of Health and Human Services and Department of Education. I think that he did bring out this morning that it would facilitate what the educational group could do if there were more direct grants made to the Department of Education or budgeted to the Department of Education so it could make direct grants without going through a process of having to justify it to the central funding of HHS. I am not sure how that is done, but I think I understood that you felt that that would be helpful. Am I wrong or right in that? This would be a specific possibility that we would consider for a recommendation if, indeed, that would be helpful.

MS.HUBBELL: I do not think I was speaking directly to the grants going to one specific agency or organization, be it the Department of Education or CDC. Funds are definitely needed in all areas, health education, health prevention as well as education. I cannot personally tell you how best I think the funds should be distributed. Currently the funds that the National Association of State Boards of Education are receiving in cooperation with CDC, are having a positive impact at the state level with our programs and projects. NASBSE will begin working with seven states in the near future, helping them set state policy, working with the local districts on current issues about AIDS. It is a very complex issue, as you know.

I do not have a specific recommendation on the funding, distribution who should be funded in order to get the funds to the local districts. My goal is to get it to the state organizations and to the local districts so that they can impact

with good curriculum. The other thing I really wanted to stress was good in-service education for our teachers. Every teacher in every district must be educated and understand AIDS education and sex education, and feel comfortable talking about the issue because each one of our students feel more comfortable with certain teachers so everybody must be prepared. Dr. Walsh, I cannot answer with a specific recommendation. Somebody else on the panel might be more informed to better on the funding.

CHAIRMAN WATKINS: We are going to have to move on, Dr. Walsh.

DR. WALSH: Can I get an answer to my question please?

MR. HOWE: Very quickly, I think unfortunately too often in education, we have a tendency of circling the wagons and then firing inward, and I think it would be a lot better if we had one spot that we are familiar with dealing with that we could go. The most important factor, though, is getting the money out as fast as possible with some solid criteria behind it.

CHAIRMAN WATKINS: Dr. Primm?

DR. PRIMM: Yes, Mr. Tolsma, I have a question concerning the CDC's large budget for education and for both in and out of school kinds of programs. What is the CDC doing to monitor and evaluate the programs that become the recipients of those dollars that you will funnel through state and local education agencies? That is the first question.

MR. TOLSMA: The grant procedure we actually enter into is what we call cooperative agreements, which in fact define roles for both the recipient and the sending agency, in this case, CDC. It requires that as part of their applications, recipients both commit themselves to evaluation and show us how they are going to do that, and we have a plan to do that.

In addition to that, we have been working as well on several things on how one defines what the outcome should be that should be measured. I mentioned the National Academy of Sciences' project a little earlier. That includes advice to us on what indicators ought to be monitored to show whether or not something may be accomplished in behavior change. We have worked with the first 15 state and 12 local recipients to agree on what we call common data items. These common data items are basically AIDS-related knowledge, attitudes, beliefs and behaviors that have been developed into a joint survey instrument. Data gathered by this instrument will be used by funded stated and local education agencies to track and monitor the level of these knowledge, attitudes and practices in the population.

I do not have specific information at this point in

time, but we have something on the order of 20 or 30 state and city school districts that either already have administered that instrument or are in the process of doing that on a random sample of young people in their state or in their city to assist the district. So we would hope that within the year, we would have some sense of what is the distribution out there of knowledge, attitudes and, indeed, of practices. Not all of them have asked the practice questions in getting to sensitive questions of human behavior but a number of them have, so we are going to, I think, begin this process of saying where are we because in order to know where we have gotten, we have got to know where we were or we have started.

DR. PRIMM: Dr. Boyer, you have spent time in Atlanta and New Orleans and San Francisco and now in the great city of New York, and you probably have witnessed in all of those major urban areas, the decay, the disillusionment, the disenchantment, the disenfranchisement, the poor housing, and all of the other things that the Kerner Report reports now after 20 years of happening in our inner cities, in particular to our minority community. This is the kind of person that you get in the schools that you have to impact with your AIDS education. You also stated in your presentation today that in your survey, there was less knowledge found among the minority youth than among white youth. What do you suggest to this panel and to this nation that would be a way to get that knowledge gap up among those youth, and to engage them in a process where they would, say, embrace what we are doing?

None of you talked about the dropouts, except you mentioned the number - 1.2 million, 1.5 million and God knows what that true number really is. I would think that the emphasis and education in terms of HIV infection and AIDS ought to be concentrated on elementary school, intermediate school and junior high school before they drop out, because those great numbers or percentage of dropouts who participate in that at-risk behavior are far greater than the people who stay in the school would have been had there been an impact prior to dropping. If you can answer that, Dr. Boyer, I would certainly appreciate that.

DR. BOYER: I will respond to your first question. The point I would like to make, first of all, is that I think the discrepancy in level of knowledge, attitudes and beliefs among minority adolescents has nothing to do with intelligence per se. I think it has to do with a lack of sensitivity to information targeted specifically at this population. Largely, until very recently, it has been a perception that AIDS is largely a gay, white, male disease, and I think for many reasons, minorities in general but adolescents in particular have ignored, the messages about AIDS and who can be infected and who are infected. I think that is changing a little now with the increasing numbers of IV drug abusers being infected, largely in inner cities.

I think that there has to be some sensitivity to those barriers to receiving information. Talking openly about homosexuality and in a lot of communities it is taboo, but it is also a particular issue in minority communities, to openly talk about homosexuality and the risk of engaging in homosexual behaviors so that has to be, understood when you are targeting minority adolescents, that you can talk about these things and you have to get over their barriers to say that is not an issue for me, even though they may, in fact, be gay or bisexual so there has to be sensitivity to those cultural factors as well when targeting information. I think that is a key.

In terms of your second point, if I understood it correctly, is that we have to "catch," as you said, adolescents at an early age, before they drop out. A large number of them drop out by the 10th grade, and if we want to implement education, say, as it now exists in a lot of school districts, in the 11th and 12th grade, it is much too late. We have to start earlier than that, and I think we can then have an impact perhaps on behaviors for those kids who will not return to school after 10th grade. I am not sure I answered all of that question.

DR. PRIMM: I think you did well. I tried to drag you into the whole Kerner report and make you all think about some of the social dislocations that our people face in this nation which make them disenchanted with the schools themselves. What is the need to go to school if I am not going to be able to achieve very much and get a job? If I am going to join the list of the unemployed like my daddy and like my uncle, etc., etc., I think that when we talk about this problem, and particularly in education, that we have to begin to think about the dislocations, the social dislocations within our society that predispose to some of these deleterious effects that we are witnessing today. I want you all to take that into consideration as you make suggestions to the Commission. That is all.

CHAIRMAN WATKINS: Dr. Conway-Welch, I think we have time for one quick question.

DR. CONWAY-WELCH: Yes, my apologies for being late. I am addressing this to Mr. Tolsma but perhaps any of you could help answer. On page nine of his testimony, recommendation number two states "Education about AIDS should be taught by regular classroom teachers in elementary grade, by qualified health education teachers for others in the secondary grades." My question to you is that obviously, school nurses are a possible resource for this education. I am aware of the fact that in many of the states across this country, there are no school nurses in any of the public school systems in the state. Tennessee is considering legislation even now about the issue. What specific obstacles other than money have you been able to

identify that have prevented or would prevent the expansion of nurses into school health programs. There are many other reasons besides AIDS education, but certainly that would be part of it. If it is a long, lengthy answer, I would appreciate receiving it in writing, but if you have any ideas other than money, verbally, I would appreciate your answer.

MR. HOWE: Real quick, one of the problems is certification of that individual to teach within the classroom and to be acceptable to the state regulatory agencies which govern how we operate our local schools and who is allowed to teach and who is allowed to have pedagogical responsibilities.

DR. CONWAY-WELCH: It was pointed out to me that as Dean of the School of Nursing at Vanderbilt, I could not teach in the state, in the public school system, but I was not aware that that was one of the big barriers for school nurses. Are there any others that you are aware of? Again, other than money.

MR. TOLSMA: The point about training and in-service training was brought up. The American School Health Association is one of the participating organizations here and that is a professional organization in which school nurses are involved.

MR. HOWE: I might note, too, that again, from the standpoint of what we do is in the development of curriculum, those districts which do have school nurses or school health access will definitely rely upon and involve those people in the development of curriculum.

DR. CONWAY-WELCH: Thank you.

MS.HUBBELL: And in many states, the school nurse can come into the classroom and be a resource person. There must be a certified teacher in the classroom, but health professionals can give the information and be there as resource peoples. They cannot teach the course entirely without a certified teacher in the classroom.

DR. CONWAY-WELCH: And that varies state by state.

CHAIRMAN WATKINS: Thank you very much, panel members. It was a very valuable panel to the Commission, and we will stand recessed now until 1:15.

(WHEREUPON THE MEETING WAS RECESSED FOR LUNCH TO BE RECONVENED AT 1:15 P.M.)

AFTERNOON SESSION

CHAIRMAN WATKINS: Welcome back. Our first panel this afternoon concerns the views of elected officials about AIDS. Governor Edward DiPrete, from Rhode Island and, also, from Rhode Island, Representative Claudine Schneider, and Congressman Sander Levin from the 17th District, State of Michigan will be able to join us.

We have pressing time constraints particularly today on Congresswoman Claudine Schneider who has a vote coming up shortly. She must go back to Capitol Hill. So, with the Governor's permission, we would like very much for Congresswoman Schneider to give us her statement first.

CONGRESSWOMAN SCHNEIDER: Thank you very much, Admiral, and let me say at the outset that I appreciate the opportunity to testify, and I want to begin by commending you for the leadership that you have provided in what has to be one of the most incredible challenges that this country has ever faced and let us hope that we will ever have to face.

I know I speak for Governor DiPrete when I say that we appreciate this opportunity to inform you about the AIDS battle in Rhode Island and what I believe is a model program for other states to emulate. Rhode Island, as you know, is a very small state, but it is not so small as to be unthreatened or untouched by the AIDS virus. By the end of last year we had diagnosed about 144 of our citizens with AIDS. Sixty-six of those, regrettably, have already passed away. These statistics are, granted, below the national average. Our response to them, however, I believe, has been well above. While the numbers are frightening to us, for many, the letters A-I-D-S are even more so, and this fear has been perpetuated most through ignorance of the disease.

Unlike the disease itself, the myths and the misperceptions about AIDS seem to spread by mere casual contact. There is nothing blissful about this kind of ignorance. Like an unreliable blood test for AIDS, it creates false positives -- undue fear -- and false negatives -- insufficient concern. It is incumbent on government, therefore, I believe, to provide our citizens with the most accurate information available about the disease. Pending a cure, AIDS education is our most effective weapon to stop the spread.

Now, let me share with you, and you will probably hear from Congressman Levin shortly, members of Congress are very anxious to respond to the AIDS threat. Despite the budget crunch most of us fully support and will continue to support the growing budget, for AIDS research. We should, also, do what we can to remove the bureaucracy from the researchers so that they

can expedite the search for and production of a cure for AIDS. Beyond that I would hope that my colleagues will join me in legislative caution. For now AIDS is not a question in search of a legislative answer. Still, we in Congress are asking ourselves what is it that we can do to help educate our constituents about AIDS? While we can provide federal funds and incentives to develop AIDS education programs, we do not possess the kind of sweeping powers of office that governors have at their disposal. So, instead we have to look for creative ways to reach the people of our states.

Over the past several months I have been endeavoring to do just that. Late last year I sent a 20-question survey about AIDS to every household in my Second Congressional District. It looked like this. First of all, the purpose of this was to determine as best as I could through a very unscientific sampling the extent of the awareness among my constituents, and secondly, perhaps most importantly, I wanted to create a sense of inquisitiveness among Rhode Islanders. I wanted to ask them or have them ask themselves if they really knew all that they should about the disease. Whether or not they took the time to fill out the response card and send it in, most of all the survey got them thinking about AIDS. More than 5000 families responded to the questionnaire which is rather significant as any congressional survey goes, and overall I believe the results were outstanding.

On questions that were relating to the spread and the prevention of AIDS respondents scored around 90 percent or even better, and I would ask the Chairman's permission to include this questionnaire and the results in the record, if I may?

CHAIRMAN WATKINS: Without objection, it will be entered. Thank you.

CONGRESSWOMAN SCHNEIDER: Another part of my AIDS strategy, of course, was to send out the answers to the questionnaire, and with those answers, I, also, included the Surgeon General's report on AIDS which as you know, is one of the most comprehensive booklets on the disease.

Just this past Monday I added another dimension to my AIDS education effort. I spent the day meeting and talking with professionals around the state included in the AIDS research, prevention, treatment and education angle. Originally a member of this Commission, Dr. Burton Lee had been scheduled to join me, but unfortunately, inclement weather forced us to postpone that visit. Nonetheless, I look forward to the time when Dr. Lee will be able to join in. I think that he will find that there is much to see and much with which to be impressed in our State of Rhode Island.

There is a multipronged battle being waged in our state. We are attacking AIDS on the three most critical fronts: research, health care and, also, education. Researchers, scientists and physicians at Brown University and various hospitals are engaged in a wide range of research on the HIV virus and other community health projects. The State Deaprtment of Health is coordinating additional research, as well as overseeing a public awareness and education program focused on high-risk groups, all part of a $3 million initiative by Governor DiPrete and the Governor's AIDS Advisory Council.

There is, also, a volunteer group called Rhode Island Project AIDS which has been established to help cope with all aspects of the AIDS crisis in our state. The organization provides counseling to AIDS patients. It runs a bilingual AIDS hotline service which is just about to start up. It provides information and educational materials on AIDS and AIDS-related initiatives, and it puts on workshops and publishes an information newsletter. They, also, have sponsored a workshop on AIDS in the workplace for corporate and business leaders.

Some of our state's best education efforts are occurring in Rhode Island's schools. If Pilgrim High School in Warwick, Rhode Island, which I visited Monday, is any indication of the effectiveness of AIDS education in our schools, and if these students eventually turn their knowledge of the disease into preventive actions, then I have very high hopes that we can significantly thwart the spread of AIDS. But as you know, only 16 other states and the District of Columbia require AIDS education in their schools.

Last summer Governor DiPrete called on his fellow governors to follow Rhode Island's lead and adopt similar AIDS education efforts in their states. That proposal was unanimously endorsed by the governors.

Mr. Chairman, I urge this Commission to do likewise, to recommend that AIDS education become as basic in the curricula of our schools as reading and writing, and based on my experiences in Rhode Island, I would especially urge the Commission to consider the following recommendations: The Department of Education should work with US Public Health Service of the Department of Health and Human Services to develop AIDS education courses and corollary materials, both print and visual, for use in the nation's schools, beginning at the primary or secondary school level. In order to teach one of the statistically most susceptible groups, Hispanic Americans, educational materials should, also, be produced in Spanish. Thirdly, I believe a central clearinghouse should be established for states to share educational methods and materials, curriculum development and teacher training information. Fourth, education programs should be targeted to high-risk groups, especially

minority communities and IV drug users and, also, education and counseling programs should be developed for use in corporate America. Sixth, in order to give our citizens an accurate understanding of the extent of the disease, the government should regularly publish statistics on the spread of the AIDS virus so that we have the opportunity to measure progress as we proceed, and in a like vein, the government should regularly poll or test, if you will, citizens on the effectiveness of our AIDS education efforts so that we know that we are spending our money wisely and that the educational efforts are having an impact.

In order to keep the public informed of the progress being made in research into a cure for AIDS, a central clearinghouse should be established for the sharing and dissemination of the most up-to-date research on AIDS and, also, any type of alternative cures. The United States should take an active role in sharing our educational efforts with other nations and international organizations, such as the World Health Organization. Similarly the United States should seek to learn what other countries and world groups are doing to educate their public. I happen to serve on the Science and Technology Committee, and we have had some hearings about information sharing on AIDS and our role in the World Health Organization. It seems to me that there is opportunity for improvement there in terms of information generation and exchange.

I realize, Mr. Chairman and members of the Commission that the powers of this Commission are very limited, just as the extent of what we in the Congress can do directly is limited. In that respect we share a mutual frustration. However, we look to this distinguished body to direct our national strategy to combat AIDS. With all the medical, the ethical and constitutional ramifications attendant to the AIDS dilemma, your mission is not an easy one, but your leadership is essential. We look toward that leadership, and I, for one, offer to provide you with any kind of assistance, congressional or personal, that I can possibly lend you. Thank you very much.

CHAIRMAN WATKINS: Thank you very much, Congresswoman Schneider.

Governor DiPrete?

GOVERNOR DI PRETE: Thank you very much, Mr. Chairman. I would like to thank you members of this Commission for allowing me the opportunity to testify today. As a sitting governor, I wanted to speak today of the role that state chief executives can play in meeting the challenges presented by the AIDS epidemic, and before proceeding, I would, also, like to take just a moment to introduce Rhode Island's Director of Health, Dr. Denman Scott. Also, Susan Barry from my Policy Office is here.

State governors occupy, in my opinion, a unique position in the American political system. Like others in public office, we stand at the focal point of public scrutiny but must at the same time be responsive to the needs of society while being responsible to the statutory and constitutional constraints of governing.

Whenever a real crisis occurs, the first person who gets called is usually the governor, and in the case of an ongoing crisis, such as the AIDS epidemic, it is the governor who is responsible for articulating and promoting the best means for protecting the people of his or her state. Fortunately, governors also possess some very important tools to assist them in carrying out their role. They command the enormous resources of state government, both in terms of money and in terms of personnel, and just as important, they can mold public opinion through their access to the news media. In using the power of personal authority, a governor can bring together the experts to sort out the facts and move toward a reasoned consensus on the proper course of action. These powers are particularly important in meeting the challenges posed by the AIDS crisis. We are talking about a highly complex issue, one of staggering importance but which is often cloaked in fear and sensationalism. It is an issue that has been further complicated by unique legal and civil liberties issues, and it is an issue that medical science itself is struggling to come to grips with.

It is, also, an issue now on the desk of every governor in every state in this nation. It is not something that can be ducked. The steps that we take today can make all the difference in containing this epidemic until a cure or a vaccine can be developed. Governors must act, and they must act quickly. We cannot afford to wait until all the facts are in, and what is more, we have to speed up the process to get appropriations through and get the programs on line. As the chief public elected official of the state, a governor's job is to get the public and private sectors moving and moving together quickly. In short, our goals are these; one, to stop the spread of the disease; two, to assure medical and social services to victims and to their families; three, to protect the health care system from being overwhelmed by new demands on the capabilities; four, to maintain the fiscal viability of care providers, health insurance carriers and the state budget itself; five, to calm the fears of the public; and six, to prevent unfair discrimination against those who are stricken by the disease.

You have already heard testimony from Dr. Denman Scott, as I mentioned, Director of Health. He was generous in describing my role in our common effort to fight AIDS and was too modest, in my opinion, in describing his own very important

role in presenting his case to me, but he was correct about the sense of urgency I feel especially about the need to safeguard our young and my impatience with a "business as usual" approach to fighting a lethal epidemic.

Rhode Island has the distinct advantage of being behind some of the other states in the onset of the disease. We are a state of modest size. We are about 1 million people, and our initial number of cases of AIDS was correspondingly low. This presented us with a strategic advantage of beginning the fight against the disease at a relatively early stage and provided us with the opportunity to learn the lessons of other states and municipalities. I felt it was imperative to use this advantage to the fullest.

There are four areas which a governor must command, especially in time of crisis; one, policy formation; two, administration of state agency programs; three, legislation; and four, public leadership.

I want to say a word about how these apply to AIDS. Setting policy means establishing goals and charting a course of action. Where AIDS is concerned, setting policy is made difficult by uncertainty about the disease, fear of transmission, disagreement about what works best and concern, of course, about civil liberties. We have to understand that good people can disagree, but this disagreement was creating confusion and was an impediment to action. Our decision, therefore, in Rhode Island was to break through this confusion. To do this I named 39 highly qualified people from different walks of life to a Governor's Advisory Council on AIDS. I told them that I was increasing the AIDS appropriation in my new budget proposal by nearly 700 percent to approximately $3 million, and I told them that they had 3 months in which to develop practical recommendations for spending the money. We didn't have the time for ultimate answers. We needed to take the best information we had now and to act on that information. You sometimes hear said that study commissions are established to avoid decisions rather than to help make them, but this is not the case. We had a real emergency, real lives at stake and real money to spend. A governor, fortunately, and Claudine Schneider alluded to this, commands the resources of multiple state agencies, their staff, budgets and programs. It is through this that he is able to work most directly. Even before we had the AIDS Council Report, we knew there were things that we could do right away through the instrumentality of state agencies.

The first thing we did early in 1987 was to beef up the AIDS Control Unit in the Department of Health in order to increase its disease surveillance capabilities, its testing and counseling services and its AIDS education programs. Second, we

asked the Board of Regents for Elementary and Secondary Education to mandate AIDS education in public junior and senior high schools. There is nothing more important in my mind than making sure our children know how to protect themselves and each other from this terrible but preventable disease. Third, because IV drug users are a major risk group for AIDS in Rhode Island, we increased the number of Methadone maintenance slots funded through the State Department of Mental Health, Retardation and Hospitals.

Our legislators, incidentally, are very much aware of AIDS, very concerned about it, a merit, in fact, to the general public which it represents, but like the public, the legislature has been divided in its perception of AIDS and how best to confront it.

Last year the general assembly was flooded with a variety of unrelated, sometimes contradictory bills as have been the legislatures in all 50 states, the impulse to do something constructive running ahead of any consensus as to what the best approach might be. This year we hope to bring a greater measure of coherence to our legislative deliberations by using the recommendations of the AIDS Advisory Council as a basis for action.

In addition to program recommendations for allocating the AIDS budget, we submitted an administration bill incorporating council recommendations to establish a balance between public health needs and civil liberties concerns. For example, one, the bill establishes the principle that people may not be tested for the AIDS virus against their will, but it does establish certain narrowly defined exceptions, for example, children, wards of the state, exposed workers and so forth to protect the individual himself or to protect others with whom he or she comes into contact.

Second, the bill establishes the principle that AIDS test results may not be disclosed without the tested person's notification and permission, again, and I stress, with certain exceptions, such as health care workers to whom victims have been referred for care.

Third, the bill bars discrimination against people who are infected with the AIDS virus in housing, employment or the delivery of services and provides for administrative relief from the state human rights commission.

Finally, the visibility of a governor provides an opportunity to take moral leadership and an unparalleled opportunity to speak directly to the people. The governor can influence opinion, calm fears, generate community support for positive action and if necessary, force reconsideration of

impulsive tendencies which may be well meaning but counterproductive. The mere fact that the governor has a personal interest, a commitment and involvement in the fight against AIDS gives a certain amount of reassurance to the public.

In addition, gubernatorial sponsorship for programs helps make them work. Let me just give you two examples, if I may. Some communities in our State of Rhode Island in the past have been reluctant to make sex education a part of the school curriculum. Inevitably AIDS education requires that we speak frankly about sexual transmission at a level, of course, commensurate with the age level of the student. I believe that my public stand on this issue, both in Rhode Island and nationally, facilitated public acceptance of what had previously been a very controversial undertaking.

I might add that in broader forums, as well, governors can use their power of persuasion to make a difference. Last year I proposed to my fellow governors at the National Governors Association a resolution recommending mandatory AIDS education in our nation's public schools. In making the case we were able to convince each governor of the importance of this step, and consequently the resolution was adopted unanimously by our nation's governors. Back at the state level a governor's opposition and, if necessary, a gubernatorial veto can force reconsideration of an overly hasty measure.

Now, I don't want to suggest that any governor can be a one-person solution to the AIDS problem. It is just not going to work that way, but governors are elected to provide leadership in terms of policy, programs, legislation, and in educating the public. Particularly in regard to the AIDS crisis, these functions allow a governor to make a material contribution to both the direction and substance of a battle whose outcome is of the highest importance to the people of an entire state.

Finally, I want to say a word about the ethical side of the governor's responsibility in the AIDS crisis. You sometimes hear about AIDS being a disease that people bring upon themselves because of their life style choices and that we shouldn't have to worry about violating the civil liberties of people who endanger others. I don't think it is the role of government to make those kinds of decisions. Under our Constitution, and we have all taken an oath, and we have sworn to uphold the Constitution, every citizen is entitled to equal protection of the laws. It is not just the right thing to do; it is the law.

As governor, I intend to continue to be tough but tough on the virus, not tough on people. Does mandatory testing

make sense? In some cases, yes, it does, and we are providing for that in law, but we do not enshrine mandatory testing as a principle. On the contrary, it must be viewed as a necessary exception at this time in certain limited cases.

Now, let me conclude by commending President Reagan for his leadership and the members of this Commission for their tireless efforts in examining strategies for dealing with this lethal menace. We do a lot of things in government, but protecting the lives of our citizens is the most important.

Again, Mr. Chairman, I thank you for allowing me the opportunity to testify today, and certainly I and members of my staff will be very happy to answer any questions.

CHAIRMAN WATKINS: Thank you very much, Governor DiPrete. I know I speak for all the panel members to say how proud we are that the State of Rhode Island would have sought presence before this Commission in such numbers. Dr. Scott testified for us 2 days ago on matters of his feeling about the overview of the public health system and its relationship to the epidemic. Congresswoman Schneider has asked us to accompany her through a variety of sites in Rhode Island to see what you are doing, and I think your personal leadership and the statement you just made gives us courage that your leadership within the National Governor's Association will spark continuing interest and attention and personal involvement by that leadership, and that is what it is going to take, and so, I commend you and Congresswoman Schneider and Dr. Scott for being so much in view before the Commission. I think it is great for you state. It shows tremendous personal involvement, and that is very important to the Commission.

GOVERNOR DI PRETE: We appreciate those comments, Mr. Chairman.

CHAIRMAN WATKINS: I know that you may have to be pulled out, but just a minute, Congresswoman Schneider, and I would like to ask one question before I pass it down the line to the other Commissioners. Where do you think Rhode Island business leadership is right now in their involvement in the entire effort of partnership with community-based organizations, with state and local authorities in dealing with this? Are they becoming involved in it to the extent that there is greater participation, a greater personal knowledge so that there is a bridge between AIDS in the workplace, AIDS education in the schools? Are there even some monetary contributions where the demand is more than state funds will allow, but they could come in and begin to help out in areas that clearly are both underserved and underfunded right now?

CONGRESSWOMAN SCHNEIDER: Insofar as the awareness of the business community in the State of Rhode Island, the workshop that was held by Rhode Island Project AIDS generated interest on the part of about 150 different companies, and the way you often measure interest in a topic when you are holding a workshop is to see who stays after lunch. As it turned out, overwhelmingly the majority of attendees at this conference, at this workshop stayed beyond and throughout the afternoon, and there was a great deal of interest.

Now, insofar as their desire to have access to information about how to educate their employees, how to provide answers to questions of insurance or discrimination or whatever, much of that information was provided to them. So, I think that Rhode Island is in the forefront of tackling the questions of the business community. Insofar as your question about the willingness of the business community to put forward financial resources to help grapple with the problem, that is something I am not aware of, but you can be sure that when I go back to Rhode Island on the weekends, I often have the opportunity to speak with the Chamber of Commerce and many other business leaders, and I will ask that question to see if they are willing to commit some resources and certainly for the generation of information about the disease I think that that would be a useful expenditure on the part of the business community. So, I will take that question and turn it into action and positive suggestion on your part.

CHAIRMAN WATKINS: Governor DiPrete, do you have anything to add to that?

GOVERNOR DI PRETE: The business community has been very supportive of this. In fact, the immediate past president, a gentleman who just stepped down as Chairman of the Providence Chamber of Commerce was a member of the Council on AIDS, the Advisory Council on AIDS. He was very active in it, and every single indication I have had from the business community that they are very supportive, both from a humanitarian point of view, and I think they feel that these are the things that improve the quality of life, and that certainly affects business.

CHAIRMAN WATKINS: Thank you very much. I would like now to, since Congressman Sander Levin, 17th District, State of Michigan has arrived to allow him to give us his short statement, and then we will continue with the questions.

Congressman Levin?

CONGRESSMAN LEVIN: Thank you very much, Mr. Chairman, Admiral and your colleagues. You have heard a lot of testimony. I thought it might be useful for me to give you a report from the grassroots, so to speak. I represent a district that is in many

respects, typical in this country, urban-suburban. It has only one farm in it. So, we don't claim we are typical in that respect. It is evenly divided blue collar-white collar, socioeconomically diverse, and yet in one respect the district is different than parts of America. It is perhaps somewhat atypical. The district includes, as I mentioned Northwest Detroit. Northwest Detroit has the second highest number of IV heroin addicts in the country. There is, also, I might add rather significant, much too much drug abuse within the suburban areas. Any drug abuse is too much, and there is a considerable problem within the suburban areas of Detroit.

We faced in our office this question, what should we do? I was a member of Congress. AIDS was spreading. What were our opportunities and our obligations? We had considerable debate. This was a number of months ago. Within our office, there was a wide diversity of opinion. There was hesitation to engage in an education campaign for what seemed to be obvious reasons. We framed the discussion, "should we distribute the Surgeon General's Report?" The decision ultimately was made by the member. I decided that we should proceed to distribute the Surgeon General's Report, and we picked out three communities, diversified communities, Northwest Detroit, which has a substantial minority population lower income than Southfield. Southfield was the second community which we picked out, which has a higher percentage of white collar than blue collar population. The third community was Dearborn Heights, a rather traditional community, in the Detroit spectrum, blue collar, white collar, and a considerable what might be called an ethnic population.

We told the staff in our main office in Michigan after we sent 100,000 leaflets, "Get ready for the deluge." We thought we would receive primarily protests. Five years ago, I don't think any office would have thought of sending material that discussed the subjects that are in the Surgeon General's Report. There was no AIDS epidemic then. As I indicated in my testimony, instead of the phone ringing off the hook with protests from 100,000 homes, we did not receive a single letter of protest or a single telephone call. I was very surprised. We had decided to hold a series of town meetings in conjunction with the report, and as indicated in the testimony a number of experts, Dr. Osborn, Dr. Thier, Dr. Fisher came to these meetings and again, we had contemplated on a very large turnout beyond the norm, and so, we selected halls that could accommodate what we thought might be very volatile meetings.

In two of the three communities a smaller number of people came than is usual. Those who did participate were vitally interested in the subject, and we had a most informative and at times controversial discussion but more informative than controversial.

I think there are lessons to be learned from this. I don't think our district is very different than the rest of the country. I think people would wish to avoid the subject of AIDS. They would wish it away, for obvious reasons. Also, the incidence of AIDS has not reached a point in Michigan where most people know somebody who has the disease. So, in that sense it seems remote, but also, it is clear to me from our experience that most people want this information. If that were not true, we would have had a large number of phone calls like we are receiving today, and we have received the last few days on AIDS, and I was struck when I went to Europe on a trip with the Select Committee on Narcotics how far behind this country is compared to other countries. We went to Portugul, and I brought with me what they are disseminating through the postal service in Portugul, a country whom one might think by tradition would never send this kind of material, but they did and long before we did, and so, as I indicate in my testimony, it seems to me that several points are clear. We have learned from the grassroots within the 17th District the following: AIDS is a threatening subject. Most people prefer to avoid discussion of it. Two, people know that AIDS is a serious subject, so they will accept clear information about it; and thirdly, even though most people wish to avoid and at the same time learn about it, they don't feel it is yet close enough to home to leave their living rooms, attend meetings, initiate discussions or otherwise become involved in the subject, and that increases the obligation, it seems to me, upon those who have responsibility for education in this country.

Finally, as I say, in my testimony, regarding education I think the experience in the 17th shows the following: First, the message must be clear, and if you would like, I can spell that out. Secondly, the message must be complete. The public needs no less and will accept candor. Third, the message must be repeated. Fourthly, the message must be carried by leaders in the community. We scheduled as a follow-up to the town meetings a session with community leaders, private and public, local leaders, municipals, church, education. They came in large numbers. And lastly the message cannot wait.

I read the testimony of the Secretary, of Mr. Bennett this morning, and I must say when you look at his testimony in relationship to our experience in the 17th District, it strikes me that it sets up an absolutely false dichotomy. It is not a question of teaching responsibility or providing information. There is nothing inherently contradictory. They must go together. He says that we should not be afraid to talk about the demands of decency, self-respect, personal responsibility in the presence of the young, that is exactly what we are trying to do within the 17th District. We, also, I think, should not be afraid to talk about the nature of the illness and the nature of

avoiding it, in addition to the supreme obligation of youngsters and others to meet the demands of decency, self-respect and personal responsibility.

We have a student forum in our District. We meet three times a year. We had one the previous year on drug abuse, and I was astonished at the descriptions by the students of the nature of drug abuse in the schools of this District across all lines. I think it is misleading to talk about condom mania. That isn't what our effort was involved with at all. It is a question of meeting our responsibility for education, and I close with this. I want you to know what moved me more than anything else. I said to myself, "Doesn't every family deserve the kind of information about AIDS that my family has?" My wife and I have four children. They range in age from 19 to 29. Then it was 18 to 28, and I had to ask myself the question, being immersed in this issue, reviewing the materials, should not there be within every household of this country the same information for parents and children to use as we were able to utilize within our house. And believe me, in our household, as old as the children are, it is not a question of either/or. It seemed to me I had just one answer, and that was I should not sit by and see that my children and our family, when it comes to a fatal illness, is advantaged over any other family.

You have taken important steps in other areas. I hope you will do the same in the field of education.

CHAIRMAN WATKINS: Thank you, Mr. Levin. I would like to open it to questions now on my left, Dr. Conway-Welch?

DR. CONWAY-WELCH: Governor DiPrete, I would like to ask you a question on your testimony. On Page 9, No. 2, the administration bill talks about the principle that AIDS test results may not be disclosed without the tested person's notification and permission, with certain exceptions, such as health care workers to whom victims have been referred for health care.

Could you expand on some of the rationale behind that?

GOVERNOR DI PRETE: The rationale for the exception?

DR. CONWAY-WELCH: Yes.

GOVERNOR DI PRETE: Referring to health care workers - the health care workers have a right to such information, certainly to protect their own health. I think if there is a substantial exposure that they should at least be aware of it so that they can take the necessary precautions. We are not saying that the health care personnel should not expect to treat AIDS victims. I think they should, but I think that they should be

aware of the type illness that the person has so that they can be properly protected.

DR. CONWAY-WELCH: Thank you.

CHAIRMAN WATKINS: Ms. Gebbie?

MS. GEBBIE: I appreciate the comments that each of you made, and I am not really certain to whom this question is addressed. We have heard considerable testimony that the kinds of things many people believe are important to young people and adults as well about HIV infection - how to protect themselves- are intertwined with a whole range of issues about being a healthy person and a healthy member of our society. A number of witnesses have indicated that this should be a part of a more comprehensive health education attack that gives people tools for healthy living in all aspects of their life. There is an impression, in at least some quarters, that elected officials are more interested in small bites of things, that AIDS education is more politically palatable than comprhensive health education which sounds huge and unaccomplishable. Is it realistic that we look at this more comprehensive approach and say, "Yes, AIDS is important, but don't take it out of context. Take it in a broad sense?" Do you think that, in fact, elected officials can get behind that broader viewpoint if it were put forward?

CONGRESSWOMAN SCHNEIDER: I certainly think that insofar as curricula being developed in individual states that a comprehensive approach is probably the best approach, but I am particularly biased when it comes to health care and to education because it seems to me that we need to educate the American people about body systems and about the entire body, the mind-body connection.

I think that even in the elementary schools, I have a document from the Centers for Disease Control, and the question has often been raised, where do you being teaching children, and do you take, as you asked, a piece of the action or a broader approach in terms of education? Even in dealing with early elementary school, I think one of the most important things to first get across is to eliminate the fear, to let children know that one does not get AIDS easily and that one should not be afraid of being near or touching someone and that scientists all over the world are working toward a cure. I think integrating information about AIDS of this type can come in small pieces, but ought to be part of the whole educational health program.

CONGRESSMAN LEVIN: Let me just add that I think the answer is yes, but again there has to be a rule of reason. There is an urgency here. So, I don't think you teach one piece or another. Again, I think there is no conflict between

emphasis on moral values and information. There can be, but you teach both, and you base it as broadly as you can. Otherwise it will be misunderstood. But I think you would agree, you don't want to try to teach a PHD course to elementary or secondary students, but it does need a context. Also, we have to remember its urgency. I fear we are losing the sense of urgency about the spread of this disease. I am glad for data that indicates the threat may be less than some feared, but it is there, and for those who may be attacked by the illness, it is totally there.

GOVERNOR DI PRETE: I might add to that that prior to February 1987, it was the official policy of the Board of Regents for Elementary and Secondary Education in Rhode Island not to mandate AIDS education in any form in the public schools, and after talking to Dr. Scott and others on this issue, I felt just the opposite. In fact, I wrote to the Board of Regents and asked that they reverse their policy and mandate AIDS education, as a part, as you say, of a comprehensive program of health and family living. The health and family living curriculum obviously was intended, and I stressed this in the letter, to be given at a level commensurate with the age level of the student, to be introduced no later than grade 7 and the Department of Education working with the Department of Health did come up with pilot programs, and they started going around the state several months ago. I know at one particular school a number of parents attended. This was advertised as a private program that would likely be introduced into the school system to teach about AIDS, and the parents went to the junior high school. Many of them were quoted in the press as saying that they went there intending to oppose it: "we don't want it; you are intruding on our rights" and so forth. Seeing the professional way that it was presented, directed at the age level of the students, part of an overall program of health and family living, the parents there unanimously supported it that night. I think this has been the key to it, that it is identified as part of the whole picture of improving one's knowledge of health.

MS. GEBBIE: Thank you.

CHAIRMAN WATKINS: Dr. Lilly?

DR. LILLY: Governor DiPrete, I had intended to approach a little bit the same question that Dr. Conway-Welch approached earlier. In the three recommendations or the three examples that you give, you do talk about certain exceptions to the barring of mandatory testing or at least one exception to the idea of confidentiality. You don't speak of any exceptions to the right to discriminate or the lack of a right to discriminate against persons with AIDS. I have problems with these exceptions. For example, if health care workers have a right to know the HIV antibody status of their patients, is the opposite also, true? Do patients have a right to know about the

HIV antibody status of their health care workers? Then one --

GOVERNOR DI PRETE: I can answer that by saying that all the institutions supplying health care delivery in the State of Rhode Island obviously operate under the supervision of the Department of Health. They are required to be certified. The Department of Health periodically, on a regular basis, inspects the premises, the operation, the supervision, the staffing. All these things are overseen and monitored not on a daily but on a regular basis by the Department of Health.

DR. LILLY: I am sorry, I am not entirely clear exactly how that answers the question.

GOVERNOR DI PRETE: Maybe I am misunderstanding you, but I think the generic question is probably on oversight on both sides. I will leave this to Dr. Scott, if he wants to amplify it. I don't say that the Health Department goes in and conducts a blood test on each of the people who are employed by the hospital. Is that your question?

DR. LILLY: Yes, partly. I mean that is one aspect of it, yes. I think one has to take very seriously exceptions to the idea of confidentiality simply because of your third point here which is the great potential for discrimination.

GOVERNOR DI PRETE: Let me talk on that third point. The bill bars discrimination against people who are infected with AIDS virus in housing, employment, delivery of services. I had some questions on this, and the rationale was, for example, specifically in employment. If one infected with AIDS was in some kind of an occupation and with competent medical testimony it could be shown that there was with reasonable certitude a danger to the health of other people who might come in contact with the infected person for example if the AIDS person worked in a restaurant or worked at delivery of services that conceivably would be contagious to other individuals - competent medical testimony would have to establish a legitimate reason for the practice of discrimination. It would not be easily done.

DR. LILLY: I think I will pass.

CHAIRMAN WATKINS: Dr. Lee?

DR. LEE: Governor DiPrete, I want to commend you on your judgment in appointing Dr. Scott. He is one of the most thoughtful witnesses we have had before us. He is a very high-class professional and I hope you can keep him.

GOVERNOR DI PRETE: I concur.

DR. LEE: Congressman Levin, are you on Charlie Rangel's Subcommittee?

CONGRESSWOMAN SCHNEIDER: No.

DR. LEE: But you were with him?

CONGRESSWOMAN SCHNEIDER: Yes, I was with him.

DR. LEE: I have had a good bit to do with his Subcommittee, and I have great respect for his dedication to this drug abuse problem. My question to this group of panelists is do you agree with us that drug abuse is the major problem? Where do you put it? We feel in the medical profession that drug abuse may be the major health problem in the United States of America today. What is your position on that?

GOVERNOR DI PRETE: I don't think there is any question that drug abuse certainly is a major contributor to the infection of AIDS, and the drug problem that we are all addressing, both on a state level and on a national level. What we are all saying is that it is not about to be solved overnight. It is complex. We are working through it from an educational point of view to reduce the demand on drugs. We are working through it from a law enforcement point of view, but there aren't enough, as I have said before, there aren't enough state policemen and Coast Guard ships and everything else to stop every illegal shipment of drugs into the United States. I think the long-term solution is addressing the demand side through education, and there is no question that drug abuse is a major root cause of the AIDS infection problem.

CONGRESSWOMAN SCHNEIDER: There is no question in my mind that as we in Congress attempt to grapple with the supply end of things which is really limited insofar as our control, that oftentimes we have a tendency to overlook the demand side, and it is very clear to me that we are now in the era of communications. In the olden days members of Congress could come back to their districts with a bag of money and say, "We are going to build a new bridge or we are going to build a new justice building or this or that." Those times have changed.

The best thing that we can bring home now to our constituents happens to be information, and I think that we need to develop the types of information transfer to young people and to working adults. I mean I have been informed that there are as many people taking drugs on Wall Street that could cause the collapse of our economy. So, it is an all-pervasive challenge that we have, and I think that there is no question that we have to focus on information about drug addiction and its relationship

to AIDS being one of the major challenges of the century.

CONGRESSMAN LEVIN: I very much agree. My trip I took with Chairman Rangel and Mr. Gillman and others just underlined the seriousness. Surely on the supply side we worked more than on the demand side. But I mentioned my experience within the District and our student forum. I don't think I am surprised too easily, but to sit there and listen to students from 20 public and private high schools cutting across, as I mentioned, all kinds of lines, talk about drug problems in their schools, I don't know how we can do anything but marshal our resources and approach it from all sides. Again, I think the dichotomy approach is a serious mistake. It isn't either/or. We have to attack the demand side in terms of moral values for sure, discipline for sure, education, information for sure, treatment. What you said last week or was it this week, is so true. If you just look at the statistics in Detroit, the 80,000 IV heroin addicts, 10 percent infected with the virus, if we follow the same pattern as New York, it would mean 40,000. That is beyond one's imagination. So, drug abuse is a serious issue without regard to AIDS. When you combine the two, it is a set of issues that demands our immediate attention. It won't be done just with one thing or another.

DR. LEE: Thank you.

CHAIRMAN WATKINS: Dr. Walsh?

DR. WALSH: I think I will address my comments to all of you and ask for yours. We all, of course, are very much impressed with the emotional impact that AIDS has had, not only on the country as a whole, but particularly on law makers because it does attack a young, vibrant age group, both in the minorities and in the gay community. That it is a sentence of death gives it an urgency that you referred to, Congressionman Levin. One of the things, however, that concerns me is that we have had the drug problem for a long time. In this era of limited resources, budget problems and the like, even with its association with AIDS, this budget has been reduced. We have had teenage pregnancy. We have had sexually-transmitted disease of all kinds for years. We have it on the rise now, despite many years of education, and yet, we see a tendency to legislate funds just for AIDS. You made a point, also, Congressman Levin, that was significant. There comes a time in the attention span of the American people - somehow they are even reading glimmerings now - there are erroneous reports that it is tapering off as a concern. I am, also, concerned that in the rush for funding for AIDS we are taking funding away rather than adding funding or rather than providing new funding. We may be taking funding away from other things that are, also, in need, and I wondered whether you, Governor, in your Conference of Governors feel from the sense of your colleagues that the problems of

sexually-transmitted disease or long-term care which are involved in the AIDS epidemic are things that the governors are ready to tackle. Both of you members of Congress, as you well know, have been wrestling with long-term care problems for what, at leat the last 8 years and probably longer than that. As we get down to appropriating funding and urging funding, are we going to be taking from Peter to pay Paul or is it in the mood and the spirit of the Congress today to bite the bullet on the fact that AIDS is a disease which will and should require long-term care but the long-term care problem itself in relation to other diseases needs handling? In the field of health education, as Kris Gebbie spoke of earlier, are we prepared to urge our schools and our PTA's and whatever to go to a broader base of health education and of respect for one another and our fellow man? Are we concerned with the civil rights of the uninfected, as well as the civil rights of the infected? How are you going to handle that? I mean these are questions that I would love for all of you to voice an opinion on.

GOVERNOR DI PRETE: It is my job as a governor, doctor, first of all to identify and recognize the problems and services that are required of residents of my particular state. It is my job in the formulation of my budget priorities to deal with each of these based on the seriousness - and of course AIDS is extremely serious. To show you the progression that we have gone through in this particular area in just 3 years - 3 years ago, for the first time we had recommended an appropriation in the state budget to address AIDS. Like you mentioned, several years ago, this just simply wasn't on the agenda of most of us in government. I recommended $120,000, a mere pittance, you might say. The General Assembly was not ready, I guess to deal with it as a priority item and they reduced it to $60,000.

The following year, 1987, the budget request was around $350,000 to $400,000, and this year we have upped it to nearly $3 million. I have not heard anybody come forward yet in the General Assembly and say that I am recommending too much money. Is it a new expense? Is it a new demand on our resources? Yes, it is, and I don't think it is a question of either/or. It is important enough, certainly that it is a responsibility I have as governor to tackle and include this in the priority of services that we have to render. I think it is important, the last point, to get the neighborhood groups and parent groups' support of a comprehensive program of health education. I think they go hand in hand. If we are ever going to get this thing under control, and we are doing that - Rhode Island was the first state in the country to mandate AIDS education - I look for more states to adopt that same philosophy and same requirement.

CONGRESSWOMAN SCHNEIDER: When I look at the challenge

that we have to face in terms of AIDS, I look, and perhaps you do it in a more broad fashion, but I categorize it in education research and then, also, in long-term care as you have delineated, but it seems to me that it is necessary to set our priorities when we have limited resources. So, I would like to share with you where I see the priorities coming in each of those areas. Are we taking money from Peter to pay Paul? In the area of education I think that if we spend the money wisely, which I surely trust that we will given the make-up of this Commission, given the directives that have already been coming from this Commission, it seems to me that any money spent on education is money well spent because it is preventive in nature. I think one of our major challenges right now is to focus as many resources as we possibly can to prevent further spread and greater understanding and to diminish the degree of fear that is running rampant throughout the United States and the world right now.

So, I think that that needs to be a high priority. Forewarned is forearmed, and there are too many people who have been acting out of ignorance, and now, I believe that ignorance is beginning to subside based on the statistics that you are currently looking at in different social groups.

The second area of research, where are we taking from the research budget to put more into the AIDS? I serve on the Science and Research Technology Committee. I have served there for 8 years now.

Let me share with you that the Federal Government, right now, spends 73 percent of our research dollar on defense. We have stolen from Paul in the area of cancer research and AIDS research. We have stolen from energy efficiency technology. We could build national security for this country by increasing or, excuse me, reducing our reliance on foreign oil. We have taken monies away from materials research which has been detrimental to our balance of trade. There are a number of different areas where research has suffered as a result of our large investment in that one sector of the defense economy. It seems to me that research dollars are not the only way to address the problem, but addressing the bureaucracy is. I think this is an area where Congress can take some actions, where we can support legislation that would speed up the grant review time that has taken from 12 months to perhaps 6 months and provide money so that we might have more people available to review those grant applications to see if there are alternatives to AZT or what type of inoculations or preventive measures might be available.

So, I think that there are actions other than dollars spent in the research area, but those are well placed, considering where we are placing our priorities with the federal research dollar. The private sector is investing a considerable

amount of money. Sandoz Corporation and a number of others are investing in AIDS research, and that should get the moral support of this Commission and, also, the President.

The third area you mentioned, long-term care, as a representative of the people, it is my responsibility, I feel, and the responsibility of governors throughout our country to provide for long-term care. I think this is a civil rights and a human rights issue, and certainly if we do first challenge appropriately the educational challenge, then that long-term care will not be that long term, and if we speed up our research, perhaps it will not continue to be long-term care either. So, if we act expeditiously on one and two, not always throwing money at the problem, but speeding up the bureaucracy, we will have a significant impact, and I think it is resources well spent.

CONGRESSMAN LEVIN: Let me respond to your question, Dr. Welch: drawing, if I might, upon the hearings we held when I was on a government subcommittee, and we had testimony on the issue of AIDS four years ago. First of all, budget priorities won't be set well, even discussed well, if there is a vacuum of leadership, and I think first we had a vacuum of leadership on this issue. That was true in 1983-84, and our efforts won't work very well if there is divided leadership, and I am afraid there is such in Washington.

I hope you can put this into perspective and provide a clear message, not indicating that there are all easy answers but some clear messages. Secondly, for a while, reflecting the vacuum of leadership, funds were being shifted around. When the Under Secretary of Health came before us almost 5 years ago, there was a clear tendency to minimize the AIDS question and the need for research, the need for education. In those days, I remember the hearings so vividly, to minimize the need for everyone to have access to AZT was unfathomable to me and others of us on the committee. But in the last years, on a bibpartisan basis within the Congress, monies were allocated, not taken from cancer research and putting it into AIDS research. But it takes leadership, if you are not going to rob Peter to pay Paul. Let me also, if I might, comment briefly on the question of the civil rights of the uninfected. I think everybody's civil rights have to be attended to here, and there are some thorny issues. I wouldn't deny it, but I think we must resist the temptation to pit people against each other in this arena or to follow other agendas or to have the issues relating to AIDS be thrown against broader canvasses. Let us fight out those other issues some other place than in relationship to a fatal disease, unless they are directly relevant.

I just know from our experience in the 17th, 200,000

leaflets being mailed to this diverse population and then town meetings and then municipal officials and others gathering together. The public really doesn't mainly want the AIDS issue to be an arena for debate of other issues. They want government to lead, to educate, to research, to provide care and yes, to tackle the thorny civil rights issues but to get on with it. They are waiting for our leadership. They don't want to argue over the appropriate role of government because in an area like this, if government doesn't lead, who will? Not do it all, there is a distinct role for the private sector, and we are going to be debating some bills in the Congress in the next months and the issue of civil rights will very much be there, but again, I hope we resist the temptation or the tendency to move to a resolution by dividing us. I think the nation really wants some unity on this issue. They recognize what a threat it is.

CHAIRMAN WATKINS: Thank you very much.

DR. WALSH: That is why I asked the question.

CHAIRMAN WATKINS: We are fairly late and imposing on your time. We don't have assembled before us very often people of your stature and position in decision making. We would like, perhaps, if possible to take about another 10 minutes, but if you must leave, we will understand, and you will not offend us. We are imposing on you, and we recognize that, but we would like to go on for a couple of more questions from the Commissioners.

DR. SERVAAS: My questions will be addressed to the governor, and I congratulate you on a very good presentation and, also, for your support of the gentleman at your right. Governor, we were told that prison guards and guards in jails are themselves pushers of drugs and/or drug addicts. In Florida we are told that illegal drugs are as easy to obtain in jail as out of jail. If this were true in your state, how would you handle it, and my second question is our hearing today is on AIDS prevention. Does it bother you that an estimated 80 to 90 percent of those who are infected, probably in your state, as well, don't know that they are infected and therefore, won't be able to prevent the spread to their sexual partner? Do you have any comments about that and how you think in the future it could be handled?

GOVERNOR DI PRETE: On your first question of drug activity in prisons or involving prison guards, I think to be perfectly candid that it is a known problem to happen around the country. To what degree prison guards might be involved around the country, I am not so sure. I can only say that the operation of prisons today is a more severe problem, the administration of them is more severe than ever in our history. As you are aware, we have a rapidly growing prison population around the country of

some 8 to 10 percent, putting drains on the resources of prisons, and in my own state budget that I just submitted to the General Assembly, the largest growth in any department was in the Department of Corrections. It was not that I wanted to put my priority that way, but that was the right thing to do out of necessity. I could only say that we closely monitor, as closely as possible, what activities the prison guards are involved in, what they are doing. We would come down very severely, extremely severely on prison guards who have been shown and convicted to have introduced drugs into prison to sell them, exchange them, whatever. It is a problem that we are dealing with, and I dare say that it will never go away completely, but all we can do is monitor and deal extremely severely with the highest penalties possible.

And your second question, dealing with the exchange of information --

DR. SERVAAS: My second question was do you have any ideas or does it bother you or could you comment on the fact that in your state probably 80 to 90 percent of teenagers and all those who are now infected with the AIDS virus don't know that they are infected? Do you have any ideas about that, does that bother you?

GOVERNOR DI PRETE: Of course it bothers me, but I am not ready to start imposing mandatory testing on a carte blanche basis. I have taken a public stand against it as far as state employees are concerned and in any other jurisdiction of the governor. I believe where there is a reasonable possibility of someone having the AIDS virus or there is a high-risk situation that there is a special case, and by the way, it could involve going back to your first question. It could involve activities around a prison. Then I might say that in those specific cases, and only in those high-risk cases, would I be comfortable with imposing mandatory testing. I would not be comfortable in a free society as we live in to say that every person walking the street or every person applying for a job be it the public industry or private sector would be subject to a test. I would not agree with that.

DR. SERVAAS: I don't think any of us would, but what I guess I am asking is do you have any ideas about encouraging voluntary kinds of testing, since this is on prevention of the spread of AIDS?

GOVERNOR DI PRETE: Again, on prevention and spread, I think the greatest hope, and while this may answer your question in an indirect manner, I think the greatest hope of prevention lies in education - how AIDS is contracted; how it can be prevented; and any and all means of prevention. Introducing this in schools around the country is the key to the prevention of the

spread of AIDS. Other approaches might be Band-aid approaches, so to speak, but the overwhelming effects will come from widespread education on the contraction of HIV and how to prevent it.

DR. SERVAAS: Thank you.

CHAIRMAN WATKINS: Dr. Crenshaw, one quick question?

DR. CRENSHAW: In the interest of time, I will defer to you, Admiral.

CHAIRMAN WATKINS: We want to thank this panel very much. You are very kind to take the time to come down from the Hill at this important time, and you, Governor - I know you have a plane to catch. We would like to keep our dialogue open with you, all of you, as we have with other witnesses.

We are open until 24 June by our charter and would like to keep that avenue of communication open with the very much involved and interested leaders in the country. So, if that is permissible with you, we will continue that dialogue. Thank you very much.

Next is a special panel that deals with student perspectives, and we have a very special witness in Mr. Ryan Wayne White, a student at Hamilton Heights High School, Cicero, Indiana. With him is Ms. Jill Stewart, Student Council President, Hamilton Heights High School, Cicero, Indiana, and we, also, invite Ryan's mother, Ms. Jean White to sit at the table, and perhaps she would even allow us to open questions up to her. I know she is not going to make an initial statement. We are particularly honored to have people like Ryan come before us. We have had many others with HIV infection come to the Commission. They have given us unique insights that no one else can give. They have, also, given us the sense of urgency that I think you will find within the Commission. They have, also, inspired us. So, Ryan, if you will come up to the table, if you are here?

I would like to welcome all three of you to the Commission. Ryan, we would love to have you tell us anything that you feel would be helpful to us as we deal with this epidemic in the country.

MR. WHITE: Thank you. I am Ryan White, and I am 16 years old. I am here today to tell you of some of the hardships and struggles of dealing with hemophilia and AIDS. When I was 3 days old, the doctors told my parents I was a severe hemophiliac, meaning my blood does not clot. There was a product just approved by the Food and Drug Administration called Factor 8 which contains the clotting agent found in blood. While I was

growing up, I had many bleeds or hemorrhages in my joints which made it very painful. Twice a week, I would receive injections of Factor 8 which clotted the blood and broke it down. A bleed occurs from a broken blood vessel or vein. The blood then had nowhere to go. So, it would swell up in the joint. You could compare it to trying to pour a quart of milk into a pint-sized container.

The first 5 to 6 years of my life were spent in and out of the hospital. All in all, I led a pretty normal life. Most recently, my battle has been against AIDS and the discrimination surrounding it. On December 17, 1984, I had surgery to remove 2 inches of my left lung due to pneumonia. After 2 hours of surgery the doctors told my mother I had AIDS. I contracted AIDS through my Factor 8. When I came out of surgery, I was on a respirator and had a tube in my left lung. I spent Christmas and the next 30 days in the hospital. A lot of my time was spent searching, thinking and planning my life.

I came face to face with death at 13. I was diagnosed with AIDS, a killer. Doctors told me I was not contagious. I was given 6 months to live, and being the fighter that I am, I set high goals for myself. It was my decision to live a normal life, go to school, be with friends and enjoy day-to-day activities. It was not going to be easy. The school I was going to said that they had no guidelines for a person with AIDS. The school board, my teachers and my principal voted to keep me out of the classroom even after the guidelines were set by the local state board of health for fear of someone getting AIDS from me by casual contact. Rumors of sneezing, kissing, tears, sweat and saliva spreading AIDS caused people to panic.

We began a series of court battles for 9 months, while I was attending classes by telephone. Eventually I won the right to attend school, but the prejudice was still there. Listening to medical facts was not enough. People wanted percent guarantees. There are no 100 percent guarantees in life, but concessions were made by my mom and me to help ease the fear. We decided to meet everyone half way. We agreed to separate restrooms and drinking fountains, no gym, disposable eating utensils and trays, even though we knew that AIDS was not spread through casual contact. Nevertheless, parents of 20 students started their own school. They were still not convinced. Because of the lack of education on AIDS, discrimination, fear, panic and lies surrounded me. I became the target of Ryan White jokes; lies about me biting people; spitting on vegetables and cookies in grocery stores and urinating on bathroom walls. Some restaurants threw away my dishes, and my locker was vandalized inside, and folders were marked "fag" and other obscenities.

I was labeled a troublemaker, my mom an unfit mother,

and I was not welcome anywhere. People would get up and leave so they would nnot have to sit anywhere near me. Even at church, people would not shake my hand.

This brought on the news media, TV crews, interviews and numerous public appearances. I became known as the AIDS boy. I received thousands of letters of support from all around the world, all because I wanted to go to school. Mayor Koch in New York was the first public figure to give me support. Entertainers, athletes and stars started giving me support, and I met some of the greatest like Elton John, Greg Louganis, Max Headroom, Ayssa Milano, my teen idol, Lyndon King of the Los Angeles Raiders and Charlie Sheen. All of these people, plus many more, became my friends. I had very few friends at school. How could these people in the public eye not be afraid of me, but my whole town was?

It was difficult at times to handle, but I tried to ignore the injustice because I knew the people were wrong. My family and I held no hatred for those people because we realized they were victims of their own ignorance. We had great faith that with patience, understanding and education that my family and I could be helpful in changing their minds and attitudes around.

Financial hardships were rough on us, even though my mother had a good job. The more I was sick, the more work she had to miss. Bills became impossible to pay. My sister Andrea was a championship roller skater who had to sacrifice, too. There was no money for her lessons and travel. AIDS can destroy a family if you let it, but luckily for my sister and me, mom taught us to keep going, not to give up and be proud of who you are and never feel sorry for yourself.

After 2 years of declining health, two attacks of pneumocystis, shingles and a rare form of whooping cough, I was faced with fighting chills, fevers, coughing, tiredness and vomiting. I was very ill and being tutored at home. The desire to move into a bigger house to avoid living AIDS daily and a dream to be accepted by community and school became possible and a reality with a movie about my life, the Ryan White Story.

My life is better now. At the end of the school year of 1986 and 1987, my family and I decided to move to Cicero, Indiana. We did a lot of hoping and praying that the community would welcome us, and they did. For the first time in 3 years, we feel we have a home, a supportive school and lots of friends. The communities of Cicero, Atlanta, Arcadia and Noblesville, Indiana, are now what we call home. I am feeling great.

I am a normal happy teenager again. I have a learner's permit to drive. I attend sports functions and dances. My studies are important to me. I even made the honor

roll just recently with two A's and two B's. I am just one of the kids, and all because the students at Hamilton Heights High School listened to the facts, educated their parents and themselves and believed in me.

I believe in myself as I look forward to graduating from Hamilton Heights High School in 1991. Hamilton Heights High School is proof that AIDS education works in schools. Thank you.

CHAIRMAN WATKINS: Thank you very much, Ryan.

Ms. Stewart, would you like to make a few comments?

MS. STEWART: Hi. My name is Jill Stewart and I am the student body president at Hamilton Heights High School. The school has approximately 600 students, and our school has been fortunate enough to have Ryan attend. As you know, he is a victim of AIDS. I am going to speak to you about what our school accomplished through AIDS education. People are afraid of the unknown, and the unknown becomes known, and then people are unafraid.

In the spring of 1987, there were rumors that Ryan might attend our school. At that time our school system was already sending counselors and nurses to our county task force that had a commission for AIDS.

Due to the possibility of Ryan coming to school, the Indiana State Board of Health held inservices for both our teaching and custodial staffs. These inservices were designed to find out what we were facing, what the possibilities and dangers were and what we knew about AIDS. The eighth grade which last year would have been the class that Ryan was moving into was given a special convocation by the State Board of Health. In June 1987, it was confirmed that Ryan would begin school at Hamilton Heights in the fall. Our school had two initial strengths going. First of all, we had witnessed at close range Ryan's pain in his former community, and second of all, we had time to prepare and instruct through education about AIDS. At this point the statute had been tested so the courts would allow students with any communicable disease to attend school, and so our school began with that premise. We knew that the government had researched the disease, and they would not purposefully endanger anyone's lives or their possibility of contracting the disease. We decided that this was going to happen, and it must be dealt with. There was no reason for Ryan to go through the pain again. The issue of AIDS needed to be faced. So, we put our strength in our government and science. It had not been too long since cancer patients had been alienated for lack of understanding of the disease.

Then we began our AIDS education and instruction. In the fall of 1987, Ms. White arranged with our principal a 2-week preparation period for educational purposes. During this time period education occurred in many forms. By this time the teachers had a total understanding of the disease, and they had an open mind.

The nursing and custodial staffs were fully trained on cleaning and dealing with any accidents that might occur.

The State Board of Health Department sent experts on AIDS to our school on AIDS, and they gave seminars to our school in two sessions. These life script sessions were aimed on the students knowing the situation, understanding the disease, learning how and how not AIDS was transmitted and relieving fears due to inaccurate rumors.

Next, our principal met with each class, the freshman, the sophomore, the junior and the senior class, and they discussed the questions and fears of the students in these sessions.

Then the students were given the opportunity to meet one on one, both with counselors and with the principal to talk about further questions they might have, and the student government created what we call the "Louie the Locker," and we put "Louie the Locker" in the main hall; we put a little face on him, and we told students that if they had any questions, or if they needed to arrange a meeting with the principal or guidance counselors to just slip the note into the locker. We got a lot of response through that, and from the anonymous requests we used, we had a bulletin board to put the answers so that the whole school could freely read. For students who wanted to meet one on one with someone privately, we arranged a conference through him. It must be noted that by the point in time that we had the "Louie the Locker," and were ready for the one-on-one communication that the students weren't asking questions that were dealing with fear or apprehension of accepting Ryan, but were then asking how they could help out of compassion and what they could do for him to make it easier. Next the freshman and sophomore classes had what we call direct education, and this occurred in the PE and health classes. They dropped what they were doing, and this was still in the first 2 weeks of school that we had done all this, and they took VCR tapes, materials, films and had a cram education ceremony on the disease. Then the juniors and seniors had brief education through science classes, psychology classes and sociology classes, and teachers were encouraged to hold discussion on AIDS at any time they wanted. So, now, the administrators, the teachers and the students were educated. So, the community was dealt with. Information was given to the press, and the press told basics on the disease and where people could locate more information. We had VCR's

available and films and materials, and our principal went to many churches and other group meetings in the area to educate the community further.

The local Kiwanis club had a speaker from San Francisco who had dealt with AIDS patients before it even had been diagnosed. So, that helped with the knowledge. Then the State Board of Health had a speaker come to our school board meeting, which was held open to the public for all the parents, and they asked questions to make sure there was a complete understanding. Then it was believed that Ryan was ready to come to school, and we had a few parents call in and say, "If he is going to come, I don't know if I will allow my student to go." And the day that he came, the students told their parents that they understood their views, and they were going to go to school. I think that this stresses how important it is to get the education to especially the students. The parents need it, too, but through educating the students you create conversations at home that are based more on the education factor and not on the panic factor. From then on Ryan came to school, -- the first week was a little abnormal, but immediately they involved students in interviews and discussions. The first day of school, student government members helped get Ryan to his classes, and football members had volunteered to help carry his books which wasn't necessary. The freshmen in his class had offered their tutoring services, and people requested to sit by Ryan, and then we put AIDS into part of our permanent curriculum. So, the key, I think, has been explicit education and instruction according to knowledge to make as smooth a transition as possible.

From the beginning, experts were straightforward in answering all the questions we had which eliminated needless fears and created an open attitude.

By working with the family to respect the wishes of the patient, and working with the students to respect their concerns, patients do not have to suffer.

I have one final remark, and that is that our school has been commended on what we have done for Ryan; yet no one realizes how much he has done for us. We have learned and grown so much from knowing Ryan. He is a really warm and wonderful human being, and he has been a source of strength through all this. He puts life into perspective in many ways, and these things we cannot measure, and we have forgiven the schools who have not had-some of this time as we have due to lack of understanding and time to prepare, but now, it is time for education, for people to act compassionately to help those with AIDS.

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

We would like, I think, to have about 10 or 15 minutes of questions from the Commissioners. I would like to start on my right with Dr. Walsh.

DR. WALSH: I actually feel that to ask questions at this point is almost moot. I watched Ryan last night, perhaps as many of you did on the Ted Koppel Show. He was asked all the questions I could think of and many, many more besides, but I think that what has impressed me so about Ryan, is not only his courage, his demeanor, and his behavior - everyone has to accept his courage - but what impressed me so was what he said last night and what he said, also, in his testimony today - that despite the really horrible way in which he was treated as an innocent victim of it which is different than some - he had a compassion and an understanding of those who had fear. This is a very mature judgment for a youngster of not 16. He was younger than that then, and it must have been very difficult for you, Ms. White, as well, to feel that same compassion. But he wouldn't have felt it, if you didn't feel it. Despite the treatment you received, you were, in effect, man enough to say, "It is not their fault." I think the reward that you have received in going to another location, to another school where you were treated as a human being with equal compassion in kind is because of the leadership that you provided in your student body. With the leadership from your principal and your fellow students, you three have probably contributed more to a public understanding of what can be done with this problem that is before us and before this Commission today, than anyone. Rather than question you, I wanted to use my few moments to simply praise you to the sky for what you have done, to thank you, all three of you, for what you have done. I know, Ryan, that the Lord, in His wisdom, will give you many good years yet, and I look forward to that.

CHAIRMAN WATKINS: Dr. SerVaas?

DR. SER VAAS: Since Dr. Walsh mentioned the Lord in his wisdom, Ryan, I would just like you to tell the audience and the panel, what is the last thing you do before you go to bed at night? And then I would like you to tell them what kind of car you are going to drive when you get your license and what you are going to be? I know what you are going to be, but you tell us all what you are going to be when you have your career unfolding?

MR. WHITE: I hope to be the best person I can be, and I would like to be an architect, not an architect but an advertising agent, and as to your other question, I hope to drive a Chevy Cavalier because someone has generously donated, and I don't know, I just hope to have a good life.

DR. SER VAAS: Ryan, you are just like all the rest of the teenagers. You have changed your career plans. At Christmas you were going to be an advertising copy writer,

remember?

MR. WHITE: Yes, in advertising. I heard an architect this morning on TV, and I just was --

(Laughter.)

CHAIRMAN WATKINS: Dr. Crenshaw?

DR. CRENSHAW: I think that the three of you demonstrate one of the few things coming out of this serious disease, and that is that in its challenge to us, it is improving and forcing qualities in human nature that we don't always have to draw upon so heavily in improving compassion, understanding, tolerance, patience and learning. The gay community has found this to be true. You have been just incredible, and I think it is courageous, and the rest of the world is going to find that they can develop these qualities, too, to be mutually supportive in all of this.

CHAIRMAN WATKINS: Dr. Conway-Welch?

DR. CONWAY-WELCH: I am interested in the strategy that you used to educate the children to educate the parents, and that seems to have been rather successful for you.

MS. STEWART: Okay, originally I don't think the administrators did have a plan, and they went into it. I don't think they, at the beginning had begun or had planned to say, "Let us educate the students and then they will educate their parents." That sort of happened, but the administrators went into it with a positive attitude of let us do this as carefully and phrase it without creating a panic. The students were the logical place to start because that is what our school had control over. The administrators knew that they could get it in through our students. They went home, and they told their parents, "This is what I learned in school today," and at the time when it happened, AIDS was coming out in the press and the media, and it was well publicized, but the facts were not necessarily. We knew about the disease, and we knew what its effects were, but we didn't necessarily know how it was transmitted or what we should be afraid of. So, then when the students said, "The experts have told us that these are the four ways that it is transmitted," they went and told their parents, and the kids were -- we had such a positive, strong feeling from teachers to the students that the students took that home to the parents, and there was never any panic created. I think that was the key to that, to answer your question.

CHAIRMAN WATKINS: Ms. Gebbie?

MS. GEBBIE: I would like to follow up along the same

line. The issue of how to create a kind of positive experience that you are now describing to us is an important one, and while you, Ryan, have come through this with very positive feelings, I think we would all hate it if every school district in the country had to go through some of what you experienced in order to get to a point where kids had the knowledge they need and the system held together as you described it. Are you sharing some of your experiences, Ms. Stewart, with other school districts in your own state with student body presidents? Is there a system so that what you learned is being shared in other places that you know of?

MS. STEWART: Currently we don't have any systems intact, but we have had a lot of coverage; the press in Indiana has helped us tremendously. They have been one of the main sources of getting the information around and helping with the positive aspects of what we are doing. There was a parent in Noblesville which is the neighboring town to Cicero, and they have a parent who has -- is it the syndrome? I don't know if you have heard, but they have called our principal and dicussed how we did it. So, we have not started reaching out to others, but I guess right now the attitude is we are sort of letting them come to us, since they know how we have dealt with it.

CHAIRMAN WATKINS: Dr. Lilly?

DR. LILLY: Since I admire very much Ryan's response to the turmoil that he has been through, I would like to ask Ms. White a little bit of her feelings about the turmoil that the family went through.

MS. WHITE: My objective all along was, you know, to be strong. Ryan, all growing up, I mean even when he was little he was in and out of the hospital a lot. He had hemophilia which is painful, but at least Ryan looked normal, and he was in the hospital with a lot of kids who had severe burns, you know, that were disfigured, and that were in a lot more pain than he was. There is always somebody out there worse than you, and I always stressed that to both my kids, you know, not to feel sorry for yourself and keep thinking that everything is going to get better, and it is up to you to try to make it better. You know, you cannot just sit around and let everything come to you. You have got to go out and reach for things in life.

DR. LILLY: Thank you.

CHAIRMAN WATKINS: Dr. Lee?

DR. LEE: No questions. I just want to tell you two

kids that you are super people. You have taught us a lot, just as kids usually teach the grownups a lot, and we thank you for it. I know Ms. White feels the same way.

CHAIRMAN WATKINS: I am closing out this important part of the testimony we have heard. I would have to say that at the end of 3 intense days of often pessimistic testimony on the epidemic that you three have truly been bright lights in the dark world of this disease, and I think every once in a while it is very, very important that we have these symbols of hope that you bring us, and the positive steps and the planning that Ms. Stewart talked about ahead of time, so that Cicero can be proud and a role model for the nation in Hamilton Heights High School of how they prepared and how they did the job so beautifully.

So, we thank you for the lesson. We have heard from many adult witnesses, but we need to hear it from you, particularly you, Ms. Stewart that you set up and continued to work so hard in such a program and have found a home in school for Ryan. So, you are both great examples of what this nation is all about, and we are proud to have had you here today.

Thank you, Ms. White for allowing us to have all three of you before the Commission. I would like to give you all a round of applause.

(Applause.)

CHAIRMAN WATKINS: I think we can just take 5 minutes. Maybe you would allow us to meet you personally.

(Brief recess.)

CHAIRMAN WATKINS: The next panel is on AIDS and education in the nation's schools. I am very happy to have the President of the National Education Association, Mary Futrell, here and Dolores Hardison, President, National Association of Elementary School Principals; Dr. Eric Voth, Board Member, National Federation of Parents for a Drug Free Youth, Medical Director, St. Francis Chemical Dependency Treatment Center, Topeka, Kansas and Dr. Stephen Sroka, Cleveland Public Schools, Cleveland, Ohio.

Thank you very much, all of you, for coming. We are extremely pleased that you were able to take time, Ms. Futrell to come as the president of the organization. We are honored to have you. We would like to have you start with your testimony.

MS. FUTRELL: Thank you very much. Let me, first of all, express my appreciation for the leadership which the Commission is providing on this very, very crucial issue. The members of the NEA are most appreciative of what you have done

and what you will do regarding this issue.

My name is Mary Hatwood Futrell and I am the president of the 1.9 million member National Education Association. I welcome this opportunity talk with you about AIDS education in the schools. No group of Americans is more deeply interested in this topic than the members of the NEA, the men and women who now face the challenge of educating America's young people about the dangers of AIDS.

Education is, of course, the key to stopping the spread of AIDS. More and more Americans are understanding that there is no magic cure or vaccine for AIDS on the horizon. In fact, there is no guarantee that medical science will ever find a cure for AIDS.

That is why education is so crucial in the campaign against AIDS. The more Americans understand how specific behaviors can place them at risk for AIDS, the more likely we as a nation will be able to reduce the incidence and severity of the AIDS epidemic.

America's schools must clearly take the lead in the education effort that combatting AIDS demands. But we all need to realize that simply telling students the facts about AIDS isn't enough. AIDS cannot be treated as just another topic in the school curriculum. Teachers cannot just teach AIDS in the same way they teach Shakespeare or geometry or American history.

Lessons about Shakespeare, after all, do not need to motivate students to change their behavior in deeply personal and sensitive areas. But lessons about AIDS, if they are going to be effective, must do just that. Lessons about AIDS must motivate students to avoid the personal behaviors that put them at risk.

There are, fortunately, resources now available to help schools and community people work together to develop effective AIDS education programs; programs that can help change student behavior. The U.S. Centers for Disease Control has recently completed and published a most valuable booklet entitled, "Guidelines for Effective School Health Education to Prevent the Spread of AIDS." I am proud to say that the NEA was one of the 15 national organizations closely involved with the development of the curriculum guidelines in this CDC publication. We in NEA are now distributing these guidelines to NEA affiliates across the United States.

The new CDC guidelines recommend that AIDS should be taught as part of a comprehensive health education program that begins in the early grades and continues through high school. For each grade level, the guidelines recommend the basic

messages about AIDS that need to be taught to students.

We applaud the CDC for preparing these much needed guidelines, but we also recognize that they guidelines cannot simply be incorporated into a school district's curriculum by administrative fiat.

AIDS prevention programs that are designed to make student behavior safer raise sensitive moral as well as educational questions. The decisions about what should be taught about AIDS, and in what manner, need to be discussed in each community. Home and community support for AIDS education isn't just desirable, it is absolutely imperative.

Teachers, in other words, need to work side by side with parents. We need to work with elected officials, clergy, the members of the medical profession and other citizens to talk through the design of AIDS educational programs. Such programs just won't work -- won't help students adopt health-enhancing behavior -- if schools are delivering one message about AIDS and homes are delivering another message.

AIDS education programs also won't work unless they are taught at all grade levels. We cannot afford to postpone AIDS education until the last few years of high school. Many students have already had sexual experiences by the time they become high school juniors and seniors some by the time they enter junior high school.

Changing student behavior means convincing students to abstain from sex, to use medically accepted protective devices, and to avoid drugs. To get students to accept these ideas, we need to build AIDS education into the overall school curriculum.

We also need to understand that all teachers need training about AIDS. All teachers need to be able to speak intelligently about AIDS because, after all, students will bring the questions they have about sensitive subjects, like AIDS, to the teachers they trust the most. Those trusted teachers might teach any subject. For example, I teach business education, and many times my students would ask me questions that would have absolutely nothing to do with that subject.

We in NEA are trying to do our part to help all teachers understand the facts about AIDS. We have mailed almost 2 million copies of an AIDS fact book directly to our members. We are in the process of reprinting that booklet and translating it into Spanish because we recognize that there is a high incidence of AIDS within the Spanish community.

We are also trying to help teachers involve their communities in discussions about AIDS education. In Minnesota, New Jersey and Maryland, we are helping our local affiliates

test innovative approaches to getting a community dialogue about AIDS underway.

Frankly, that's not an easy thing to do. Most people don't want to face the AIDS issue. "We don't have the problem in our community," they say, "so why should we deal with the issue of AIDS?"

We are under no illusions about the impact of our work. No single educational organization, even an organization as large as we are, has the resources to do what needs to be done in AIDS education. And what needs to be done? Every school district in this nation needs administrators and teachers who are well-versed on the facts about AIDS and specially trained to discuss these sensitive facts with students.

Every school district in this nation also needs the support of its community for AIDS education. To gain that support, educators will have to discuss sensitive AIDS-related issues with local parents and residents.

Meeting these goals will not be easy. In fact, meeting these goals won't be possible without the help of the Federal Government. Yet, so far, the resources the Federal Government has placed into AIDS education have been pitifully small.

Let me give you just one small example. The Federal Government last year began encouraging national educational organizations, such as the NEA, the school boards, and administrators, to launch AIDS prevention projects. But the Federal Government has yet to do its part. Federal funding of these programs has been totally inadequate. So far, the only program the Federal Government has created to help national organizations promote AIDS education in the schools limits annual grants to an average of $125,000.00.

Let's take a moment to analyze this $125,000.00 figure. There are approximately 16,000 school districts in the United States today. That means the Federal Government is willing to spend a grand total of less than $8.00 per school district per year to help all national education groups combat AIDS. That is not a serious effort. That is shameful.

With support for AIDS education so low, national educational organizations essentially have two choices. One, they can send out a booklet or pamphlet on AIDS -- and hope it makes a difference. Or they can choose a few school districts and provide the kind of help that local educators really need to develop programs that change student behavior.

Neither option is adequate. If we are to win the

education war against AIDS, then the behavior of the Federal Government must change. AIDS education must become a serious fiscal priority. This is a message that the White House and Congress need to hear and this is a message that I hope this Commission will decide to send. Thank you very much for allowing me to appear before you this afternoon. I will be happy to respond to questions whenever you are ready for me to do that.

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

Ms. Hardison.

MS. HARDISON: Thank you. My name is Dolores Hardison. I am serving this year as President of the National Association of Elementary School Principals, an organization representing over 25,000 elementary and middle school principals throughout our nation. On their behalf, I want to thank you for the work that you are doing. You are bringing light rather than heat to this important issue.
I want to thank you, too, for granting us an opportunity to testify.

I am from Florida, and you know the impact that the Arcadia situation had -- not only on Florida schools, but on every school and community across this country. We cannot endlessly repeat that scenario. It is not fair to the children and their families, nor to the school community. We need to find a better way and I am hoping that through your deliberations, the Commission will identify and widely disseminate the most promising practices now being implemented so that episodes of the Arcadia type will never occur again.

There are a number of examples of promising AIDS programs that I am sure you have heard of or read about: the Washington, D.C. public schools; Longmeadow, Massachusetts; Wilmette, Illinois and Fairfax, Virginia. These school districts have developed a process and a program that have provided information rationally, communicated effectively and emphasized fact -- not fear -- in their approach.

We need to know more about these programs. We know they have succeeded, but we don't have all the nuts-and-bolts information, the "how to get started" basic procedures and understandings that will build the strong foundation that school districts want. Pamphlets and brochures, while containing valuable information, are not enough. Elementary and middle school principals call for more, and I would urge the following five steps.

First, begin early. Children are curious. They have heard about AIDS and need to have the facts. We need programs and materials to give them those facts. If we have time, I

would be happy to share some specific examples with the Commission.

Second, provide training. Principals and teachers need to hear and to be educated by health experts. We must work to educate parents. We depend on their cooperation. Adults need to develop an awareness and clear understanding about AIDS in order to communicate effectively with our children and youth and with one another.

Third, emphasize respect. The rights of AIDS victims deserve the same respect as do the rights of those who come in contact with them. It is the virus that is the enemy, not the person victimized by it.

Fourth, involve the media. Schools cannot do the job by themselves. In addition to public service messages on radio and television, the inclusion of AIDS situations in prime time television drama, sitcoms and soap operas could be very helpful. With so many people getting their education and information from television, we need greater cooperation from and involvement of the networks.

Fifth, build coalitions. School personnel, school boards, parents, health experts and community leaders working together can make a real difference. All successful programs have been built on this concept. Coalition building is a necessary prime ingredient in assuring a well-accepted and positive program in each school and community.

And people, expert people, talking with non-specialists is essential. School building staff, principals, teachers, support staff, in addition to the school community, must be educated about AIDS, what it is and what it is not. Curricular materials appropriate to the developmental level of elementary school children must be designed and produced. As I said, elementary school is not too soon to begin to educate children about AIDS.

The guidelines offered by the Centers for Disease Control are a good beginning. The project started under the direction of the Education Development Corporation looks very promising. The fact that President Reagan has proposed additional funding for AIDS information and research is encouraging. Our association is strengthening its involvement also. Surgeon General Koop, who addressed our state association leaders' conference last July, will be a general session speaker at our annual convention in San Francisco next month. (April 16-20, 1988). Program sessions on AIDS will also be featured.

Many of you have read the Newsweek, Phi Delta Kappa,

and Chicago Tribune Magazine articles that mentioned Paul Nilsen, Central School Principal in Wilmette, Illinois. Paul shared his very effective process with us at our National Fellows Program last summer and he spoke last month at the American Association of School Administrators meeting in Las Vegas. He is also serving as a consultant to a number of school districts. We need to find more Paul Nilsens and benefit from their expertise.

In addition to providing training opportunities for our member principals, we also want to help inform you on the quality and availability of AIDS programs in school districts and individual schools throughout the country. We have just mailed a survey seeking a variety of information on such areas as public awareness, school district and school programs and principals' preferences. A copy of the survey has been furnished to the Commission. As soon as we have compiled this data and written a report, we will be sure to send copies to you.

Right now, we do not have the answers to all the issues relating to AIDS in our schools, but we think our survey is asking the right questions. We are making every effort to alert our members to the help that is available and what processes seem to work most effectively.

We look forward to continuing to discover and disseminate promising practices and to work with the Commission in finding practical solutions for concerns related to AIDS in our schools. Thank you for allowing me to testify.

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

Dr. Voth, we welcome you and as a distinguished son of a distinguished Admiral in the Navy, give my respects to your father.

DR. VOTH: He sends his regards to you, too.

CHAIRMAN WATKINS: Dr. Voth.

DR. VOTH: I am very pleased to be here before the Commission and in this capacity, I represent the National Federation of Parents for a Drug Free Youth. My professional involvement is with actually treatment in that I run a chemical dependency treatment program, but in my involvement with the National Federation of Parents, I am involved in drug abuse prevention nationwide.

As I have outlined in my written testimony, which somehow didn't make it through the mail apparently, so I have provided another copy today , the spread of the Human

Immunodeficiency Virus and its related syndrome, AIDS, presents an enigma to the providers of health care in the United States today.

The changes in human values and behavior which have given rise to the spread of AIDS, have their roots in the concurrent changes in the American family. Since World War II, families have been increasingly disrupted because of pressures which have driven parents from the home, given rise to an increased divorce rate, and resulted in children being raised in single parent homes at an alarming rate.

The very fiber of the family and, therefore, our society is being eroded. As these changes have taken place, the basic mores of right and wrong, good, bad, masculinity and femininity have become blurred. Slowly, parents have not only relinquished their responsibilities in the home but they have to some extent fled them. This has given rise to a generation of hedonistic, egocentric individuals who do not have the basic upbringing to uphold healthy values for society.

Instead of parents raising their children with the appropriate nurturing and care, parents have succumbed to the trend of non-parenting and have in some cases joined the trend of deviant sexual and social behavior. As young generations have moved into the sexual revolution, rampant sexual activity has led to far more than sexual freedom and gratification. It has led to uncontrolled birth rates, tremendous rates of venereal disease and young people, who unfortunately could not distinguish unbridled sex from loving and caring.

It should be no surprise that the Human Immunodeficiency Virus became so widespread. AIDS did not simply appear out of thin air. It was carefully selected for. In some cities widespread promiscuous, homosexual and heterosexual activity resulted in hundreds of sexual contacts each year. IV drug addicts routinely use dirty needs or shared needs for multiple injections.

Any time that the natural balance is so seriously disrupted, health consequences result. For example, smoking cigarettes causes cancer. Overeating causes obesity, and a whole wide range of other examples. The major question before the Commission today is the educational process in the schools that can turn this erosion around, and I will parenthetically add that the educational process in the school should not supplant effective education and upbringing at home.

To turn this around, two of the most difficult behaviors to deal with must be dealt with; drug abuse and sexual promiscuity. It is ludicrous to think that teaching safer sex alone or passing out needles to junkies alone will make a dent in

the problem.

Specifically, programs in the schools must take a hard stance regarding sexual promiscuity and drug abuse together. We should teach that it is okay to have fluctuations in mood. It is okay to refuse to give in to peer pressure. It is okay to delay sexual activity. Teaching young people today to delay sexual activity rather than only be safe with it lets them defer that sexual activity to a time when one is more physically and psychologically able to deal with it.

While presenting a clear message, prevention programs should help identify youth that are at high risk for drug abuse and gender identity problems. Prevention programs should also help to bolster self-worth and refusal skills. Traditionally, prevention programs have either tried scare tactics on one hand or have totally lacked guidance as to what constitutes right or wrong on the other. What often appeared under the guise of responsible decision-making was often the message that no single decision was preferable or correct.

The parents' movement supports clear messages which uphold refusing these influences. No longer should prevention programs only take a soft, middle-of-the-road approach. On national and local levels the family must be revitalized. High risk families should be provided with assistance when identified. The national trend of self-gratification must be changed with a strong, national leadership to encourage parents to reinvest time, caring, attention and love in their families.

Finally, AIDS should be addressed as any other infectious epidemic. It should not be handled with kidd gloves simply because the high risk group includes a very visible and vocal minority.

I agree with Dr. Walsh in the sense that we must not rob Peter to pay Paul. The high risk group includes both IV drug abuse and promiscuous homosexuals and heterosexuals. The basic triad of prevention, intervention and treatment must be followed with, of course, particular emphasis on these high risk groups regarding AIDS, but we should not solely focus on these groups in our prevention efforts.

Hopefully, the combined approach of education to the dangers of high risk behaviors, working on communication and refusal skills and intervening on high risk individuals and families concurrently working to revitalize the American family will be an effective approach.

CHAIRMAN WATKINS: Thank you.

Dr. Sroka.

DR. SROKA: I would like to thank the Commission for the opportunity to testify.

My name is Steve Sroka. I am an inner city eighth grade health teacher in Cleveland. I am also an adjunct associate professor at Cleveland State University and I am an AIDS and other STD education consultant. Since 1984, I have trained over 8,000 teachers, who teach over two million kids and the book that I have written, "Educators Guide to AIDS and other STDs," is into its 24th edition now. I have assisted in programs in small and large cities, as well as states. I have set up programs for large Catholic, as well as Episcopal diocese.

Based on my experiences, I would like to bring you a message from the trenches and talk about what I see is wrong with AIDS education from a teacher's point of view and from a consultant's point of view. There are nine problem areas. I won't read this, just try to highlight it.

First of all, AIDS education today is crisis-oriented. It contributes to AFRAIDS (acute fear regarding AIDS). We don't need AIDS education in our schools today. When school officials show me their AIDS education programs, I ask them where is your herpes program from two years ago. We need a sound educational framework to help desensitize this educational problem. We have to allay the fears not only for our students, but for our teachers.

We have to put AIDS education into a comprehensive K through 12 curriculum. I suggest teaching it as communicable diseases. One of the things the panel might find interesting is that most of the schools and I have set up a lot of programs -- is that most schools in this country do not teach sex education. So, you go in to talk about something in sex education, and most school systems don't have it. I suggest trying communicable diseases to get your foot in the door.

In other words, what I am telling you today, with all this time and money we are talking about putting into this program, we should set up a program so that if there was a miraculous cure for AIDS today, and there is not going to be, our programs would still be viable tomorrow. Most of the programs out there could not pass this test.

The second problem, materials don't allow for local determination of community needs. You have to put out a program that respects the needs and values of that community. You have to work with these people. You have to get them involved so they get ownership and that is how you get a successful program. You have got to work with that group there. You have to have that

respect for them.

The third problem I see is materials are not teacher friendly. The programs that are out today are put together by physicians, college professors, nurses, but they are not classroom teachers. We have people trying to tell us what to do in the classroom when they have never been there. They don't understand the realities of classroom teaching today. The pains of teaching six classes a day with 50 kids and they don't want to hear what you are talking about. There is not a sense of reality to most of the programs here. You have to respect the teacher as the person who best knows how and what to teach.

Maybe the panel would not be surprised, but the average person in this country who teaches AIDS education today, the health teacher, is not a trained health teacher. They are gym teachers. Not only do they need information, they need skills in order to -- teach this subject when, the door is shut.

Teachers can't be an after-thought for the program. In most of them, there are.

Problem number four, facts are not enough. Knowing about the T4 helper cells in the ninth grade is not going to save our kids from AIDS or any other STDs. We need behavioral strategies. We have heard this several times, the skills in decision-making, stress management, assertive communication, empowerment. Let's teach our kids to take control of their lives. These skills can be taught in kindergarten. That is how AIDS education can start. It can start in kindergarten. Talk about communicable diseases and skills to take control of your life. The programs I see, have limited effect on kids' behavior. We have to teach our kids that AIDS is a disease you choose to put yourself at risk for.

Fifth problem, I find that kids do not feel themselves at risk even when they are sexually active. The statistics are well-known. I won't go through them, but one out of every seven teenagers in this country will have a sexually transmitted disease this year. There are few people in the schools with AIDS but we know with the incubation period, many of them could be putting themselves at risk.

From the classroom I get messages like -- they tell me, I can't get AIDS; I am not gay. I have had kids tell me I would rather die -- I would rather die than stop having sex. And I am telling you, the middle class value that if you have sex, you might die does not have any -- it doesn't mean anything to the typical adolescent today. As one minority student told me if this so disproportionately affects the minority people, you just tell me one, just one, famous black or Hispanic person who ever died from AIDS. I said Willie Smith. They said who, you

don't know what you are talking about, teacher.

We have got to teach that education is our only weapon. We have to get it into the kids. We have got to get relevant messages to them.

The sixth problem I see is that saying "no" is not enough for many of our students. By 17 years old, 57 percent of our kids are having sex. Perhaps we need a more realistic message. What I have found worked well in many of the schools I have worked with is the ABC's of STD's, where you stress "A" is abstinence; "B" is be monogamous or as some of my kids say, be monotonous, but monogamous, and "C" is condoms; but qualifying the condom statement with a statement that they reduce but do not eliminate the risk of infection.

I set up a program with a Catholic diocese and when I sat down with the Secretary of Education, her message could be worked out to work within the Catholic Church. First of all, they don't condone the use of condoms, but many of our kids are not living by the Christian way of life. So, we have a moral responsibility to teach these kids to reduce the risk of infection in hopes of keeping them alive long enough to kick some Christian ethics into their heads.

I think right now the "Say No" message is not relevant and perhaps the panel might consider this "Say No" message right here. Say know, not "N-O," but say know, "K-N-O-W."

Another problem, seven, materials are just too costly. Suddenly -- education is, big money. Publishers want you to buy bound books and how do you update these bound books, you buy a new book. They want you to buy student manuals. It is an extremely expensive program.

One approach is a three-ring notebook, which is a program that I developed and anybody could develop. It makes it very easy to update. In one state, I serviced the entire state, several thousand teachers, with materials for the cost of 7 cents per student. The entire program cost the state $43,000.00.

To use a competitive program that had student manuals would have cost 2 1/2 million dollars. We have to be creative here. Classroom teachers in large urban areas often have -- no budget for materials.

The eighth problem I see is everybody reinventing the wheel. Education is our only weapon but nobody is talking to one another. Nobody is sharing ideas. I hear people saying we have got to find materials. Materials are out there. It seems as if from my perspective everybody who gets a grant develops their pamphlets, their curricula, their video. People don't

realize this takes a lot of money and it takes a lot of time. Time is money. I think we have to start sharing our materials and our information with one another. We have to use existing programs. The American Red Cross has fine material or, at least, if you can work with these, at least modify them. Don't start fresh and do it by yourself.

I believe the government and agencies and foundations should stop funding programs, which duplicate programs that are already out there. We have to stop wasting all this time and money.

The last point, the last problem is that different interest groups have prevented students from receiving a consistent message regarding AIDS prevention. One group wants safer sex; another group wants teaching only abstinence. Blacks, whites, Hispanics, every group is calling for its own program but what I see is that some of these programs that go out to try to address minority needs are not sensitive enough and, in fact, they almost backfire and, in fact, they further discriminate the group that they are trying to help.

I can tell you from doing programs since 1984, that there is a strong homophobia that has never been out there before. I sense a minority phobia that is growing out there. We have to be very sensitive in our approaches to minority groups.

My recommendation on this last point is that we can no longer separate our AIDS education efforts from others because of whatever differences may exist. Schools have to work with health departments. Schools are part of the community. We have to get the total community involved; the parents, the doctors, the media. We have to work together. The three key words that we have to do to be honest with our kids is we have to get them messages that are consistent, sensitive and realistic and it doesn't matter if these kids are black or white, gay or straight, young or old.

I can tell you how it is done it in some of the communities, but I think our lives are just too valuable. I think I am on to something because I have a letter of support from Koop and also a recommendation from William Bennett, but I really want to stress to you today that -- my last point, just like in the class, sometimes you don't say it, you have to show it, is that I appeal to you that for many of our students we need AIDS education today because for some of them tomorrow will be too late. Thank you very much.

CHAIRMAN WATKINS: Thank you, Dr. Sroka.

I would like to open the questions now from the panel,

from the Commissioners, Dr. Conway-Welch.

DR. CONWAY-WELCH: Ms. Futrell, you mentioned on page 6 of your testimony that you are helping local affiliates pilot test new and innovative approaches to creating an ongoing teacher/community dialogue about AIDS. I wonder if you can give us an example of that or perhaps help frame that in a recommendation of the type of pilot program that should occur or could occur?

MS. FUTRELL: We will be very happy to help you frame it. We provided training to a team of teachers in each of the three states I mentioned. We helped develop materials, develop a training program, and learn to work with members of the community.

In Burnsville, Minnesota, for example, when the team went back, it sat down and developed a program for that community. The goal was to involve teachers, administrators, educational support personnel, representatives from the Chamber of Commerce, the medical profession, parents, and others. The team tried to get all the groups together to discuss AIDS and to arrive at a consensus about how the community should address the issues.

The first attempt was not very successful because, as I indicated earlier, many people in the community said "we do not have a problem, so why should we discuss AIDS? The team tried again about three or four months later, with more success. More people came to the meeting, and everyone discussed why AIDS education is important and why guidelines are important.

DR. CONWAY-WELCH: So, you do have a model for --

MS. FUTRELL: Yes, we do have a model --

DR. CONWAY-WELCH: Is there an evaluation component in that model?

MS. FUTRELL: We are in the process of evaluating those programs now. One was in an urban area; one was in a suburban area, and one was in a more rural area.

DR. CONWAY-WELCH: If you could share that with us --

MS. FUTRELL: We will be very happy to do that.

CHAIRMAN WATKINS: Ms. Gebbie.

MS. GEBBIE: One of the things that I hear, talking to

people trying to put something like this in the schools, is the difficulty sometimes of making the connections with a resource like the local health department and really making it a collaborative effort. I hear people from the health side saying they act like we are invading their territory when we come offering to help. I hear people from schools saying why do they want to use up our time with this extraneous stuff that isn't really education. What I have heard here is an interest in getting the materials. Could you talk about your perception of barriers to using that kind of resource at the local level, where it might exist and where there are people genuinely interested in being partners with school teachers or school districts or school principles in the process?

MS. FUTRELL: Well, I will be happy to let the others share their experiences, but the concern you have raised is a very real one. We have had a conflict or had some tension when the agency simply says it is going to come in and provide training or provide information, and there is no attempt to coordinate this activity.

Our suggestion is that the school community sit down with members of the larger health community -- the health agencies, the medical profession, nurses, and others -- and talk about how we can work together to reach not only school personnel and students, but also members of the community. We should discuss what role the teachers, for example, would play in that whole process.

When we have worked in that manner, we have been very successful. Where we have had problems is when teachers were told, "This is what you are going to have to do." Often times they are not given time to do the work. And frequently they have not been involved in developing the program. Where teachers have been involved in the planning, those tensions have not existed.

DR. VOTH: I would further expand on that, that there have been several problems. One of the most frequent that we have seen, particularly in the drug abuse area, is denial on the part of the schools that there, in fact, is a problem. We have documented severe problems in some schools where the administrations are unwilling to allow drug abuse education to take place, simply because of the fact that they have denied that their school couldn't be involved.

I think another concern is that once the door is open and they want to do something about it, the uniformity of the message has been very difficult. Some schools have been badly burned, thinking that they have gotten a quality program to come in and it has turned out to backfire.

Third, I think that programs that have put additional pressures on the teachers to be the ones teaching everything have been a problem, too, because they have got their hands full as it is. To expect them to fully reeducate about a very difficult issue, such as drug abuse and AIDS prevention, may not necessarily be the most fair or effective thing for the teachers.

MS. HARDISON: I would like to comment also that I feel we need a very strong health education program beginning at the earliest time that children come to school. In some cases they may be only three or four years old. We need to talk with children things not only about drug education and sex education, but also about problems such as child abuse. We have a program called "Me-ology," where we work with self concepts with our little children. AIDS should be a part of our total health education program.

DR. SROKA: I would share my experience in the setting of programs. The biggest road blocks I have experienced are school boards. They are elected to serve the people. I have been in school systems where you could not do anything because there was a school board election. That is the biggest hurdle.

The second biggest hurdle is teachers. There is no problem with kids. Kids want the information. I find parents extremely receptive to programs. Teachers feel, as I think we have had expressed here before, I already teach the world and now I have to teach another subject and often times it is this coach, you know. He is the guy who kicks you in the butt after you drop a pass and now he is going to talk about sex and drugs and dying. It is very difficult. And we have to put a lot of time and effort into making these people feel comfortable.

My main mission when I set up programs is to make those teachers feel comfortable and to make it as easy as possible to teach.

CHAIRMAN WATKINS: Dr. Lilly. Ms. Pullen.

MS. PULLEN: Dr. Sroka, would you expand briefly on the advantages in the tool of the loose leaf notebook type curriculum for this purpose?

DR. SROKA: Thank you, Ms. Pullen. You should all know here that several major publishers in this country told me I was just foolish to put out a book like this because truly if you put out a bound book and you need to update it, you have to buy a second one. What I am trying to do is put out a -- what I have found out is all teachers teach differently. I consider this a resource.

Teachers have their lessons plans. Sometimes they plug into the ones that I have here. The layout I have of this book, which is very unique, is that I have teacher keys with student activity sheets. So, the teachers literally can run off and they can decide in their own community what is appropriate. Can they talk about anal intercourse? Can they talk about homosexuality? Can they talk about condoms?

They decide. The information is there but the teacher decides what is appropriate in their particular community. I think that is very important. The fact that you don't have to buy a student manual puts the cost at mere pennies for students. What I suggest that people do is put one of these books in a school and xerox it as much as they would like. That doesn't rub well with many publishers, but I think when you have a format like this, you can adapt, you can grow, you can add, you can take out.

When I set up the churches, the Catholic diocese and the Episcopal diocese, they put their little insert in at the beginning on the Catholic way of life. It is adaptable and I think if we don't respect the teacher as the person who best knows how to teach it, the problem is going to be doomed to failure. So, there is not just one way to do it. We have to be flexible and we have to be adaptable and I think we have to be creative and innovative. This is one approach that has worked very well.

This is not my idea. This is 8,000 teachers talking to me. I am not using my own ideas here.

CHAIRMAN WATKINS: Dr. Lee.

DR. LEE: I sure do agree with Dr. -- the son of Admiral Watkin's cohort -- when you said that parents seem to have given up their responsibility at home. As a matter of fact, they have fled their responsibilities and they have left them to the schools. But you can't feel sorry now. You have got the problem, so let's deal with it now.

I am going to play the devil's advocate on this. Why should the Federal Government run around and give you money because there is something new to teach your students? Knowledge is your business. It is your business to teach your students about anything or everything that comes into your head. Why do you run to the Federal Government for money about AIDS? Why not run to it for a million other things?

It seems to me, and I haven't heard it here -- maybe we will hear it from the college group that comes up -- why isn't AIDS in your biology course? Why isn't simple human reproduction in your biology course? Is that a thing of the

past? Don't you teach biology? Shouldn't everybody who goes to high school or gets out of high school have had at least one year of basic comparative biology? I mean -- respond.

MS. FUTRELL: I think that the Federal Government should get involved because we are talking about a national health crisis and a world health crisis. We know, for example, that many young people will become infected. I understand that by the early 1990s that AIDS will be the leading cause of death among 24 to 29 year olds. Many of those young people are in high school or in college now. We know for a fact that within the next two years some 3,000 young people will be born in this country with AIDS. Many of them will be coming into the schools.

We also know, whether we want to accept the fact or not, that our young people are much more sexually active than we would like them to be. They could be infected right now. We also know that many of them are using drugs. Some are in school; some are out of school. What we're talking about is a national health crisis, and the Federal Government, I believe, has to be involved. We need the federal government's to help stop the spread of AIDS by helpin people change their behaviors so that they will not jeopardize themselves.

Why don't we just teach it in biology? Because I don't think it is just a biology issue. It is not just a science issue or a health education issue. It is an issue which all teachers must help young people understand and help them to address. As I said earlier, we cannot wait until the 9th or the 10th grade, which is the level where most young people would take biology. We must begin to teach them and talk to them about AIDS much earlier -- in the elementary schools, the middle schools, junior high schools, all the way through.

At the elementary school, I think the emphasis should be on reducing the fear about AIDS. We should talk to students about respecting people, as well as talking to them about AIDS itself.

At the junior high school level, we ought to talk to them about the virus, about how people get it, and, especially at the junior high and the secondary level about changing their behavior.

DR. LEE: What do you mean? What is new about this? Of course, these behavioral changes are obvious, but I don't think the Federal Government can tell you or not run around and be as promiscuous as you possibly can. I don't know --

MS. FUTRELL: In the past we might have taught a topic such as this one in a sex education class or in a health education class. It would have been the responsibility of only a few teachers. What is new is the urgency of the problem.

What is new is the fact that we all have a responsibility to help our young people know about this disease and understand how to avoid it.

I wish I could say to you that young people are not engaged in sex, that they are not using drugs, that they are not doing all these things, but as a junior high school teacher, I know better, I had too many kids coming into my classroom who were involved. How did I know? Because they were pregnant; they were on drugs; they were doing all kinds of things. So, it is my responsibility -- as a business teacher, as a citizen -- to be concerned about what happens to these young people. And I would think that our government would also be concerned.

When I was growing up, the disease was polio, and the government had to step in to find a cure for polio. I would put this disease in basically the same category. It is a very, very dangerous disease and it will wipe out hundreds of thousands of people. I don't want hundreds of thousands of people in this country to die. I don't want that to happen.

So, I have a responsibility to do everything I can to stop it, but I need help as a teacher, as a citizen, and schools need help too.

DR. LEE: Lorraine Hale -- do you know who I am talking about? Lorraine Hale, who is the daughter of Mother Hale, Ph.D., psychologist, et cetera, et cetera, stood up in Congress the other day in Charlie Rangle's subcommittee, and said that the overwhelming majority of the teenage girls, who come in to her, who are pregnant, think that God sent them the child.

Now, what went wrong? I mean, who isn't teaching them, I repeat, biology.

MS. FUTRELL: Mr. Lee, I am not here to second guess what went wrong or who didn't do his or her job. I simply know that the problem exists and that I want to help. When I see young kids coming in who can't support themselves or who are pregnant or who have all the opportunities in the world but are on drugs, I can't second guess what went wrong. I don't know what went wrong. But the problems are out there and I need your help to do something about them.

DR. VOTH: Dr. Lee, I will comment on that, if I might.

Two preliminary comments. First of all, I would hope that any AIDS efforts would be dovetailed with national drug abuse efforts because, for instance, right now the White House Conference on Drug Abuse is taking place just across town. So, we don't want to head down two separate directions here

altogether.

But I will tell you exactly what went wrong. Very close to the time of World War II and thereafter, families began to deteriorate. Very clearly, before World War II, mores as to what was acceptable, what was not acceptable, et cetera, were defined in the family. Once the family began to deteriorate and parents began to feel afraid of saying don't use drugs, don't go out and get drunk, Johnny, don't be sexually promiscuous, things began to deteriorate.

And if you look at what has begun to shake down, not only have families begun to deteriorate and those coming out of families have not been brought up with the normal upbringing of basic mores, but they also have not been given the appropriate nurturing to have inner strengths to refuse these influences.

If you look at what has happened to spread AIDS, it is very simple; rampant IV drug abuse and extremely promiscuous homosexual and heterosexual behavior. The other areas have been minor and have been off-shoots of these areas and, as controversial as it may sound, you can trace those behaviors back to what has happened with the breakdown of the family. The reason the government should be involved is the only way to revitalize the family is with strong national leadership that starts from the White House and comes down from there saying we are on a campaign to revitalize the family and the spinoffs from that are obvious.

DR. LEE: I agree with you.

MS. HARDISON: I was going to comment on the same things, and echo what Dr. Voth said about the family. The schools are reflecting what is happening in society and when we have children -- I had children in first grade, two little boys last year, who had anal intercourse --

DR. LEE: In the first grade?

MS. HARDISON: Yes. And a third grade prostitute. Society is changing and the children are coming in with different problems than the children we saw in schools ten years ago or fifteen years ago. I agree that we should not be reinventing the wheel, but we need assistance from the government for a year or two, I think, in sharing information about what is working in certain school districts. Help us get the message across and let's not wait until two or three years from now, because we have some serious problems right now.

DR. SROKA: There is just a tremendous frustration with teachers in the classroom. Everybody is telling us that education is our only weapon and everybody is giving us a

pamphlet, a video. We don't want more materials. We can read the papers. What we guys need is strategies. We need methods to do the job.

I think it is coming out here as different people have talked. There are good programs around. It is just that we don't know about them. Wisconsin, for instance, has moved ahead with initiatives. I mean, they are doing in-service for all their teachers through the Department of Health and through the Department of Education with no AIDS money. I mean, there are people that have moved without money. They have taken leadership positions and said this is a top priority and we are moving with it. I see a lot of times people use the excuse, we just need more money, when, in fact, although sometimes it is economic, it comes down to politics and egos. Sometimes you just have to say this is the problem and we are going to work with it.

So many of the ideas, I keep saying, from being a classroom teacher, my concern about drugs is not IV drug use. My concern is alcohol. Alcohol is the drug of choice. You know, our kids know the difference between a beautiful and an ugly person, six kids. Let's get drunk in school. It doesn't matter if I go inner city, little rural areas, that -- it is a social -- oh, my God, my kid came home. I am so glad he wasn't doing drugs; he was only drunk. There is an acceptance of this drug. This is the drug that sets up people to do other things and yet it is acceptable.

I think sometimes it --

DR. LEE: It is not acceptable in your age group that you are teaching.

DR. VOTH: And I would agree with you a hundred percent --

DR. LEE: It is not acceptable.

DR. VOTH: And that has been the entire crux of the national war on drugs because there is still a very definite movement to try to teach young people to be responsible, quote, unquote, with drug and alcohol use, which is a mutually exclusive term.

What the parents' movement has been trying to do is to try to teach them refusing drugs and alcohol and building healthy lifestyles. I mean we are very focused on AIDS and it is a tremendous problem but, my, God, our number one problem, our number one cause of death in adolescents is suicide and accidents and those are alcohol and drug-related largely.

MS. FUTRELL: Let me just add that I don't want us to

go away assuming that the only people who are going to get this disease are those who are promiscuous in their sexual behavior or who use drugs. The data I have seen indicates that about 80 percent of the children who are getting it get it from their mothers, and it doesn't necessarily mean that that mother has been promiscuous.

So, while we need to change the behavior, we also need to understand -- and you understand it better than I do -- that there are other ways to get this disease and other ways that young people can get it. We just heard someone testify to that effect. Ryan didn't get AIDS because he was on drugs or he was an alcoholic or he was out being promiscuous. He got it because he had an operation.

I think we also have to understand how much politics is involved here. We need to be able to transcend the politics and come up with policies, programs and curricula that will help us address the problem.

DR. LEE: Thank you.

CHAIRMAN WATKINS: Dr. Walsh.

DR. WALSH: I feel like I keep coming around the same bend all the time on this education thing. I recognize, as I said before, that AIDS is a new and dramatic -- relatively new and dramatic disease with which we are faced. I keep wondering where were not only our parents but also our teachers when we were worrying about teenage pregnancy, when we were worrying about drugs. Why is suddenly the thought of a new curriculum for one disease so overwhelming that we need, as my friend, Burt Lee says, an outpouring of federal funding to set up a curriculum for a sexually transmitted disease?

Now, granted, I know that you are talking about the innocent pediatric sufferers of AIDS and so on, but our education is -- certainly at the school level - is directed at protecting the next generation. It is really protecting the new generation that is coming because a significant part of the generation that has already gone through your hands has already been infected or has been exposed.

So, what I can't figure is why Ms. Futrell, have we not in school been addressing, whether they be in general health classes or PTA meetings and so on, these things? I assume we have been addressing family problems. I assume we have been addressing teenage pregnancy. I assume we have been addressing the incidence of venereal disease and all of these things are related to how you get AIDS.

Don't we have some foundation into which this can be

added? To me, it is a cop out when you say if the government just doesn't give us more money we can't handle this. I think that is a cop out. I mean, I think you need more money. Don't misunderstand me. I am not that far off, but to say that if we don't get money, we can't handle it and if the next generation disappears with this disease, it is someone else's fault. I keep, as I say, coming around the bend. AIDS is a horrible disease. We will have 55,000 deaths in 1991, but we will have close to half a million from heart disease and close to 400,000 from lung disease and 350,000 from cancer and so on.

So, all of these things are major problems for us and I agree with you if you can use AIDS as a wedge, as a wedge to get into curriculums what maybe parents and school boards have objected to before -- I would find it very hard to support with enthusiasm -- if the rest of the Commissioners want you to have more funds, I will go along, but without enthusiasm if those funds are even implicitly just for AIDS.

There is so much else you can do and I agree that parents have not done their share and they have to do more, too, but it just seems to me that you must have a structure on which you can build in the schools and I think, as you pointed out, you have to be sure whoever is doing the teaching knows what they are talking about because that is what parents are also worried about.

MS. FUTRELL: Well, let me try to respond to --

DR. WALSH: I would like you to address that because it really concerns me. I keep going around in the same circle.

MS. FUTRELL: Okay. I will try.

The concerns you have raised are very, very legitimate and very real. We have an epidemic of teenage pregnancies in this country.

DR. WALSH: Sure, unfortunately.

MS. FUTRELL: We have a million young women getting pregnant every year; 500,000 decide to go full term. We have an increasing number of teenagers having their second and third babies before they are 16.

DR. WALSH: Right. Now, you are talking.

MS. FUTRELL: We also have, unfortunately, a large number of young people who are becoming increasingly more and more reliant on drugs. And I am not just talking about alcohol because that is the number one problem, but I am talking about heroin and crack and cocaine. When I was coming along, going out

and having a beer, that was a big deal.

DR. WALSH: Big deal.

MS. FUTRELL: And these problems back them look pale in comparison to what we are experiencing today.

We have tried to get school districts to put in sex education programs to say to young people, "You need to stay away from sex," "you need to wait," "you need to abstain." We have said, "If you do become involved, these are the consequences: disease, unwanted pregnancies, et cetera." Many school districts have adopted such programs and put them in place. In many school districts, including mine, we have programs dealing with family education. We talk about the importance of having a strong family in place, to nurture a child. But we also stress the family as a structure that is very, very important to our society.

We have put in programs to try to deal with drugs. If we can't get students to stay away from drugs, then we tell them about places they can go to get help. We tell them about the dangers getting involved with alcohol or heroin or whatever.

So, those programs are in place. We're working with families; with the PTA, with groups like the Children's Defense Fund. NEA has set up a National Health Information Network because we know that information and many services are not available in the schools. We are working with pediatricians, with general practitioners, with school nurses, to get more information into the schools. In many instances the information simply is not there.

We don't diminish the importance of diseases like heart conditions, diseases like tuberculosis, cancer and many of the others. But what is different about AIDS is that it is spreading so quickly and that so little is known about it. While we don't have a cure, we know that if we can get people to change their behavior, we can save a lot of people -- especially young people -- from contracting this disease. And one of the best places to start is in the school.

We need up-to-date information and we need training. We have discovered that there is very little training available. Who provides the training, for example, when teachers are told to go out and talk about AIDS? Whoever provides training must have absolutely accurate information because we don't want to go out and create more of a problem than we already have.

The young people I talk to are absolutely paranoid about this disease. These young people are bright and intelligent yet they say things like, "If I sit in the same

chair as an AIDS-infected person, I am going to get this disease," or "if 'they' are in the same classroom or school with me, I am going to get this disease." "Why don't we quarantine them? Put all the teachers and all the students who have this disease in one place and make them stay there." They say things like that. And they are scared to death.

So, we need to make sure that the information we put out is accurate, that it is medically researched. We work with the medical profession to make sure the information is adaptable to schools. We work with parents to make sure they understand what we are doing. We tell parents we have the resources to disseminate materials and other information, such as films and cassettes.

This education effort should not to take away from anything else. But we must try to change behaviors which are detrimental to our young people. That is why I think the urgency is there.

DR. WALSH: That is the answer for the next generation and we have to do it.

MS. FUTRELL: Right. And we are, for example, providing training programs for our own members and for others who have asked us to help because they don't have the training programs available.

DR. WALSH: But you do feel that you have something of a structure in which to build this into, though, now, don't you?

MS. FUTRELL: Yes.

DR. WALSH: I mean, you are not exactly starting from zero?

MS. FUTRELL: No. We work very closely with the Centers for Disease Control, with Surgeon General Koop. We have worked very closely with the medical profession, school nurses, our own people, school boards, and different groups, to put this information together.

Just to give you an example of how desperate the need for training is -- we were asked by a branch of the military to provide training for some of its personnel because it doesn't don't have the training. So, we used our staff to go to Texas to train some military people regarding --

DR. WALSH: But you use these same people to teach other things than AIDS prevention --

MS. FUTRELL: Right.

DR. WALSH: -- I would hope. I really think, Ms. Futrell, if the educators, like yourself, and the educational leaders, would promote the fact that you recognize there are diseases and problems besides AIDS --

MS. FUTRELL: Well, we do.

DR. WALSH: -- that you would get a better hearing. I am glad to see you point out something about self-esteem because I was a little astonished -- one of the Congressmen, who is a good friend of mine, sort of belittled the idea of the individual responsibility because "we have an emergency." Well, where in the devil has been the individual responsibility for the last 25 years with drugs and everything else.

MS. FUTRELL: We are trying to teach young people that they are responsible for themselves and they can say "no," knowing we will provide them with the support to stick with that "no" answer.

DR. WALSH: Right.

DR. VOTH: Dr. Walsh, I would just add that there is already an excellent federal program there, too, through ADAMHA and the Office of Substance Prevention, where a lot of federal funds are coming down for drug abuse prevention efforts. The guidelines, in fact, having reviewed many of those, are identical to what is being proposed for AIDS. It would just be a matter of tailoring additional broadening of some of those programs to be substance abuse and AIDS and sexually transmitted disease. That has been one of the criticisms that I have placed to OSAP is the same thing. Why only focus on drug abuse? We need to broaden that and focus on other issues as well, but there is a federal framework for that and I think it would be a terrible mistake to get off on a second tangent here, massive federal funding to a whole separate AIDS approach, when there are other networks that exist to address the problem.

CHAIRMAN WATKINS: Any other questions? Dr. Lee.

DR. LEE: It seems to me -- here is another thing that might respond to it -- it seems to me that AIDS would make your job easier and more difficult -- it is a terribly fascinating subject that gets you into an assortment of subjects that you teach. It gets you into biology. It gets you into psychology. It gets you into anatomy. It gets you into family matters. It gets you into sexual matters. It gets you into all the things

that you are interested in teaching and it gives you an instrument that brings it home to the kids. It seems to me that it is a great tool to use in the primary and secondary school system. Am I right?

DR. VOTH: Absolutely.

MS. FUTRELL: Yes. I was very curious -- I was talking with some teachers the other day who were talking about teaching this across discipline lines. I was trying to figure out how do you teach this in math? How would you teach it in history? Or how would you teach it in business education? In history, you can relate AIDS to other plagues we have had throughout history. And in business, the cost. And, so, all of the sudden, I see there are ways to bring it up and relate it to what you are doing in your class.

DR. LEE: The ills of society are all intertwined in such a dramatic fashion.

DR. VOTH: Dr. Lee, I would add, though, the real key is going to be very similar to what happened with drug abuse. Instead of trying to teach people how to get away with it and not catch it, it is how to prevent the behavior in the first place because if they are thinking now, if I only stick my needle in Clorox or if I only wear a condom, I am going to be safe, that just is not going to address the problem. It is phenomenal how many of my drug addicts come in wanting AIDS data. It is phenomenal. It is an excellent way to open the door to the whole overall problem that you have suggested, but I think we have to be on the prevention end.

MS. HARDISON: I would like to make one final comment. One of the problems we have seen in working with parents -- is that they were a little leery when we started bringing sex education into the elementary schools. They wanted to know who is going to do this; what is the curriculum going to be like. So, we did have permission from all the parents before their children participated in this.

Some teachers are hesitant. They are uncomfortable to talking about AIDS or sex education, and to combat their reluctance we said that there would be a specified curriculum. As a principal, I want to be sure that the curriculum -- what teachers are going to say in that classroom to the children -- is accurate and that not just anybody is going to be talking about it. I think this is an assurance that we need to give our parents -- that it is a very informative curriculum and that it will be good -- and then our parents will buy it and they will let their children participate. But they need that assurance. That is why I tend to support having in a school several teachers who will be almost specialists in health education, even in the

elementary school, who will follow set guidelines, a specified curriculum, rather than just everybody in the school talking about it.

Certainly, all teachers should be aware and be able to answer questions, but there are differences in the abilities of people to give that information. We want to be sure that it is correct.

DR. LEE: I can only speculate about that terrible thing you told me in the first grade.

MS. HARDISON: It happened. I had a little boy from South America, who had been used by some older boys in South America, and he came to this country and one day he went into the bathroom and said want me to show what they did at my other school.

Then I as the principal sat and had to tell the parents of the other little first grade boy what had -- guess what happened in school today.

The children do see - hear AIDS. They will hear comments from this Commission on the evening news and they are very aware of what happens. I have very strong feelings about child abuse. I think we need to teach these children not to let anyone touch their bodies in an offensive way.

DR. LEE: It is possible that you people need combat pay.

CHAIRMAN WATKINS: Dr. Conway-Welch.

DR. CONWAY-WELCH: One of the previous panels today when I asked the question -- mentioned that school nurses would have to be certified to teach the students about AIDS, in fact, if they were used to teach about AIDS. And it was pointed out to me that as dean of the School of Nursing at Vanderbilt and I teach a lot, that I could not teach about AIDS in the Public Health School System in the school down the street in Nashville, Tennessee. I wonder if you would comment about that. That seems to be a significant barrier.

MS. FUTRELL: Well, we work very closely with the school nurses, and we certainly have not said to them that in order to work in the schools or to work with us, they must be certified. The way to address that problem, perhaps, would be for a certified teacher to invite a school nurse, a certified teacher would be there, but you would still have to talk with and teach my students about AIDS or perhaps another topic. The certification issue does not have to be a barrier. It might be a barrier in some states, but in most states, I would not think so. In my school district it is not a barrier. I can invite the

school nurse to come in and talk about different things. I have to stay there in that classroom with the students, but I can invite the nurse to come in and talk about any health-related topic.

DR. CONWAY-WELCH: That doesn't seem very cost efficient, though, when we are looking at ways of delivering the content to the student by telling experts that they have to be monitored by a teacher.

MS. FUTRELL: But that is not unusual. When we invite resource people to come in -- I would categorize a nurse as a resource person still we are the ones responsible for the class.

In most school districts, there is not a full-time nurse at the elementary level. There may be one at the secondary school. So, you would have to share a nurse with another school. I doubt school districts would be willing to pay to bring in an outside expert to conduct the kinds of discussions you are describing. So, if I want that discussion to take place, and I feel that I cannot do it, I would use someone from the profession.

DR. SROKA: The problem I have seen around the country is that there are just enough school nurses and that in most states, they are getting one nurse for three or four different schools, but they are utilized very often because they are the medical experts within the school.

I set up 24 different programs, including statewide programs and large cities and small city programs and if you would like to know some of the problems I have had in that -- I find it very interesting that I have probably set up more programs for more states and more cities in the country and nobody wants to talk. They all want to do their own thing. I find that very frustrating. It is very difficult right now. I think there is something about this disease where everybody wants to do their own thing. They want to get their grant. They want to roll with it and I think that is very frustrating. If people could just start talking and sharing and letting us see what each other has been doing -- I am going to come to the National Association of Elementary School Principals. I am doing a workshop there and that is going to be my message. We have got to start sharing information with one another and if people are saying something you don't like, you have to at least listen.

I can't rule out somebody because I don't like the way they think. We have got to sit down and get our methods together. I hear people saying, well, you are not saying what I am saying, so I am not going to talk with you and our kids are losing out.

CHAIRMAN WATKINS: Ms. Gebbie, another question.

MS. GEBBIE: Yes, a bit of a shift. We have really been talking about the kids in the school during this period of time and what has occurred to me a couple of times while you were talking is what we heard from witnesses yesterday, who pointed out that they were worrying about these kids who drop out of school and what we should do about them. Their experiences have been that is very easy for a kid to get out of school but once out, it is almost impossible to get them back in. Many barriers are erected for the return to school of a child who has once dropped out.

That strikes me as rather odd because it ought be the reverse of that. It ought to be very hard to somehow escape from the clutches of schools and if you should do so, that it ought to be easy to get you back in as a part of our solution.

Was that just a phrase that actually has no meaning in fact? What is your experience about the schools and the people who work in them being interested in having some share of responsibility or involvement with these kids who have dropped out, who are not a part of the system right now?

MS. FUTRELL: The National Educational Association has launched a program to try to keep young people who have been identified as potential dropouts in school. Today some 30 percent of the children drop out every year. So, we are talking about a million children dropping out before graduation.

So, we have tried programs that try to keep these young people in school, programs that give them skills to help them get a job or go to college.

We have also tried to get dropouts to come back to school through a regular program or a night program. Once they drop out, the problem is not so much getting them to come back as finding them. If you can find them and persuade them to come back, all they have to do is go to the school with a parent or guardian and indicate a desire to go back in. As long as they are within the legal age there's no problem. If they are above the age, of course, they have to pay. But the real problem is finding them, once they are out in the community, so you can persuade them to come back.

Many of them do go back to night school to get their GED. How do we get information to this group about AIDS? We have to rely primarily on the media and on agencies in the community that work very closely these students.

We also have programs that try to keep students in school, called Operation Rescue. We have been relatively

successful, but it is very difficult to keep students in school because there are so many other competing factors.

DR. SROKA: Can I comment? Working in a lot of inner cities, we have a disease of color out there, but the color is not black or brown. The color is green. Poor kids don't get good educations. They don't get good health care. In the system I am in half of the students drop out of school and I am concerned because -- by the time they graduate from high school, half the kids -- half my nirth grade students will not graduate from high school. I am very concerned because when I am in class teaching, the real kids that are at risk are at home putting themselves at risk. They are not in the classroom.

So, my problem is then how do we try to access these people. Sometimes we hook up through the health department. When they go in for sexually transmitted diseases or other health problems, sometimes that is a teachable moment. You might try to access them then. What I have done in several cities now is hooked up with local media people that have appeal -- for instance, in Cleveland we have an adolescent type show on Friday night. We brought these people in. We brought in Michael Stanley, who is a rock star, and we put together a program and we showed it on a Saturday from 12:00 to 2:00 in the afternoon. We are going to put that back on in prime time again.

Sometimes I have done other specials in other cities on holidays when all kids would be home and we could access the kids. Maybe while they are lying in bed putting themselves at risk, they might be watching this program. I think we have to be creative; we have to be innovative and we have to look at different ways we could work with these people.

I have been surprised that often times school kids take messages home to their brothers and sisters, who are not in school. They educate their parents. So, I think a lot of times, you know, we have to make everybody into AIDS educators and we are going to have to be creative in trying to hit this student that truly at risk because they often don't live by our values and the things that scare you and me don't scare those people. So, we are going to have to look at it in ways that maybe we haven't looked at it yet and use these people, if we can, to get help us get the message to those people.

MS. HARDISON: I think it is wonderful that we have a strong national movement now to do something about the kids who are at risk, who are potential dropouts. We can identify those children. We usually have a profile as early as third or fourth grade. We can tell you who is at risk and we are doing things about it. So, that is one good note. I want to bring some good news here.

DR. VOTH: One of the things that has been found, particularly with the K through 12 type of prevention programs is that when the prevention programs are in process, it is so easy to see these kids that are shut down with their communication. They come to school hungry, come to school dirty, come to school very tired and -- but that is why it is so important that we don't just start in junior high or high school, that we really look at a K through 12 program, while the kids are still locked in in their early grade school years, to try to intervene early, rather than try to catch them when it is too late.

CHAIRMAN WATKINS: Let me close out the panel with one question. We have had testimony, rather significant testimony, where we are hearing words like "comprehensive school health," "education health promotion plans" and so forth. We had one witness this morning, who is a representative of the National Association of State Boards of Education who talked rather positively and optimistically about the strong health education program in the State of Kansas in one sense, but she also said she had put on "Health Education/AIDS" in order to really get attention and get support in that area.

What I would like to ask Ms. Futrell and Ms. Hardison, both, is if you had to grade the United States, A, B, C, D or F, on the degree to which we have now in the country, across the nation, a solid health education, health promotion program, preschool through baccalaureate level, what grade would you give the nation as a whole, recognizing that there are going to be differences across the states? If you had to give a mark, Ms. Futrell, what would you give us? Integrated as curricular, not extracurricular, integrated with school, understanding our own human biology, a baseline on which we can absorb a thing like AIDS, STDs, teen pregnancy, all the stresses coming into the ethnic exchanges, the 30 percent of the kids born into poverty, all of the issues that HHS says are projecting us at a very rapid rate towards a chaotic situation in health of our young people if we don't get on it? Isn't it time to take a hard look at ourselves? It is telling us something. It is a plea for something much more fundamental in the way we treat education in its relationship to good health practices and the like.

So, I would like you to give us a grade from your point of view and you also, Ms. Hardison, not just for the United States, but also for elementary schools, what grade would you give us? How well do we do there on fundamentals at that level of maturation?

MS. FUTRELL: If I understand the question you are asking me, I believe I would give us a D.

CHAIRMAN WATKINS: Good for you. I would give us -- it would either be a D or a D minus.

MS. FUTRELL: Yes, I was leaning towards a D minus.

CHAIRMAN WATKINS: Everywhere we turn, we uncover the rocks of this epidemic. As we look through things, we see a plea for some much more integrative approach. I asked the Secretary of Education today what monies has he requested to pull the Department of HHS and Education -- there have been attempts made in the past and rejected. No funding by the Congress. On the other hand, isn't it time to review the bidding -- when we threw out the baby with the bath water on that one, to bring education and health back much more into harmony in its fundamental sense so that we have a place to put these various things instead of a lot of different band-aids on the shelf because we don't know when the next mutant is going to come around the corner. We don't know what the next event is.

It seems to me that the lesson learned here is that we have learned that we have a terrible situation in the country regarding this. I would like to know if you agree with that and if you, Ms. Hardison, agree with a D?

MS. HARDISON: I was going to say a D, maybe a D minus or -- we don't give E's, but in this case, I would give an E for effort. We are giving a little bit of effort but not enough.

CHAIRMAN WATKINS: People like you always get an E for effort but I am looking for the absolute mark for --

MS. HARDISON: The absolute mark that I would have to put on the card would be a D because we do have below average programs.

CHAIRMAN WATKINS: Do you think that if the Commission were to bring additional witnesses before the Commission, who have in depth knowledge in this area and have been pushing -- there are foundations, there are many groups, the Committee on Economic Development made up of academics and business people, who are very concerned about it, people like Children's Defense Fund - if we could bring that kind of pressure to bear, isn't there an opportunity here, in addition to the AIDS-specific education, health education and health promotion practices, to open up that issue and make some recommendations that would reinstate in our country a much more fundamental approach to our own health and our knowledge? Wouldn't we learn to respect ourselves and our neighbors a little bit better?

MS. FUTRELL: I believe that we would and I believe that the United States of America, the people of this country,

would be absolutely shocked if they knew that millions and millions of children in this country, the most affluent society in the world, do not have good health care. They do not have access to good nutrition. We are abusing generation after generation of children in this country in terms of health care.

I don't think people are conscious of what we are doing to the young people. For many young people, the only medical care they receive is through a school nurse. That is it. And if there is no school nurse, they do not have access to medical care.

For many, the only nutritional meal they will receive is what they get in school. For many, there is no one who really cares whether they are in good health. We are trying to work with these children on a day-to-day basis but I see the situation getting worse rather than better.

I am absolutely amazed at the number of families which do not have insurance, and can't take the child to get medical treatment. So, the situation is very bad, much worse than people believe.

CHAIRMAN WATKINS: There is a tendency, I think, for everyone to think of education in this context of being somewhat -- let's say at the secondary school or something of that nature, when, in fact, we are facing very fundamental issues that go back even to prenatal. At the 2000 Conference here last year a lot of people were saying to start health educaation at early adolescence; other people were preschool, but the general thrust is get going early -- get into it early and worry a lot about it.

MS. FUTRELL: Just look at the infant mortality rates in this country, for example. The infant mortality rate in Washington, D.C. or Detroit is worse than what we would find in Third World countries. So, I think if you decide to bring some people forward representing the Children's Defense Fund, the School Nurses Association or other groups, you will be enlightened by what you will hear. You probably will also be shocked.

CHAIRMAN WATKINS: Would you two be willing to write me a personal letter in follow-up to this discussion on fundamental health education and health promotion? Perhaps some ideas of how and who you might recommend to bring together on a rather urgent basis.

We on the Carnegie Council are looking at a middle school package. David Hornbeck is running our task force to put health education in a strong movement with lots of money behind it - to move it out into those areas that really are ready for

it. So, I think it is very timely now and I would hate to miss this opportunity to get on the fundamentals, as well as on the specifics of this virus.

MS. HARDISON: There are some states that right now, I think, are doing some very exciting things, like Colorado and Missouri, that have parenting classes and they are working with parents. They are working with the mothers before the babies are born, prenatal programs. I think there are some really good programs and I wish that all of our students would have that. But we need to get those people together. You are right.

CHAIRMAN WATKINS: Thank you very much for coming before the Commission today and we would like to maintain our contacts with you from now until our Commission goes out of business in June. Thank you very much.

MS. FUTRELL: Thank you.

CHAIRMAN WATKINS: I would like to call the next panel up and then I am going to turn the chair over to Dr. Crenshaw for a brief period. It is on college/university education. Our panelists are Dr. Arthur Sandeen, Vice President for Student Affairs, University of Florida at Gainesville. We have Dr. Richard Keeling, Director, University of Virginia Department of Student Health; President-elect, American College Health Association; Chairman of the American College Health Association AIDS Task Force; James A. Kellar, Student Counselor, University of Virginia and Laura Jill Flickinger, Student Counselor, University of Virginia.

Welcome to the panel and I will turn over the chair now temporarily to Dr. Crenshaw.

DR. CRENSHAW: Welcome.

Dr. Sandeen, would you begin, please.

DR. SANDEEN: Thank you very much, Dr. Crenshaw, and Members of the Commission. I want to express my appreciation for this opportunity to comment on a topic of great importance to all of us. I can assure you that those of us in colleges and universities view this problem as a high priority and now one of our most critical responsibilities.

I would also like to acknowledge today the outstanding work of my colleague to my immediate left, Dr. Richard Keeling, Director of the Student Health Service at the University of Virginia. With his help and leadership through the American College Health Association, those of us on college campuses now have excellent resources, policy advice and educational programs available to us and it is through his positive leadership that I

am here today and the programs -- at least on my campus at the University of Florida -- are doing as well as they are.

My comments, and I will shorten these from the written ones that I submitted to you, focus mainly on the kinds of responsibilities that I consider as a student affairs administrator on a large college campus of 35,000 students. It is my assumption that every college and university has a responsibility to its students to provide the most accurate information currently available about AIDS and to raise the level of awareness about this disease.

How does a process like this get underway on a college campus? Well, at the University of Florida and at many other institutions around the country the most effective way has been to approach the president of the institution, primarily through the auspices of the Director of the Student Health Service and other key administrators on the campus.

Usually, this takes the form of a presidential committee on AIDS and that is what we have done at the University of Florida. Such committees ought to involve medical personnel, faculty, legal staff, student affairs deans, campus clergy, psychological counselors, public affairs officers, student government leaders, residence hall staff, minority students, representatives of gay and lesbian student groups and physically disabled students. We have had such a committee on our campus operating now for about three years.

What kinds of obstacles are frequently confronted by such groups on college campuses? As I said before, it is very important to have the support of the institution's president so it is clear that the work of the committee reflects the goals of the institution. Certain groups, of course, may complain to the university that the institution should not deal with this topic because the subject matter may encourage behavior that they consider inappropriate or immoral. Others may express other fears and suggest that the university discontinue any support for gay student organizations, for example. Parents may even demand that the institution adopt various restrictive policies and some members of the college community may insist on the free distribution of condoms or the sale of them in college residence halls.

Some institutional administrators, fearful that sexually explicit language or pictures in AIDS educational materials may not enhance the college's image may attempt to screen or even censor publications.

Finally, some students may not trust the institution to keep its counseling and medical records confidential and, thus, may be hesitant to use the campus services.

Now, these matters, of course, are very serious and well-known to members of the Commission, but they pale in comparison to the three major obstacles that we find on college campuses that face us in our educational efforts: fear, ignorance and apathy. Strenuous efforts will be needed to combat these problems. Students, of course, often think their youthful vigor that makes them invulnerable to any disease and out of fear of its consequences may ignore educational efforts directed at them.

Youthful apathy may actually be avoidance or denial because confronting one's sexuality may be too threatening, especially for young people struggling to establish their own sexual identities.

We have several components to our AIDS educational programs and as the American College Health Association recommends, any AIDS education program on a college campus should have several aspects to it. We have effective publications that have been made available through the ACHA that we have distributed to students. We also have developed specific publications of our own that we distribute to every enrolled student at the university, together with a letter from the president of the institution. We think it is that important. Very key, of course, for an educational institution is to educate the gatekeepers, as we call them; those counselors, teachers, student affairs staff, medical staff and the like, who will have contact with students on these issues.

Good video tapes have been made available and we are making use of these in several areas of our campus. Perhaps the most encouraging part of our educational program in terms of its positive impact upon students -- and I think you will hear more about that from the students here from the University of Virginia -- is peer group facilitators. Making use of trained volunteer students in residence halls, in fraternities and sororities, in classroom settings and in a number of other areas, I believe, is the most effective way to develop programs that have the potential of really changing student behavior.

We are fortunate at our institution to have a very active student health service, as well, and we have two full time, professionally-trained health educators there. However, most of our activity on our campus through this committee has been out of class; that is, through the extracurricular program. One of the things that we need to do more of in all of our institutions around the country is to build AIDS education and good health education programs into the classroom experiences of all students. I will conclude my comments by mentioning various messages that I think that we should be sending through our university and college AIDS education programs to our students.

There is fundamental disagreement about the propriety of educational messages to prevent AIDS, according to Harvey Feinberg at the School of Public Health at Harvard. He urges us to avoid ambivalence in our educational message. Too often the messages people receive are either reassuring or alarming. So, our obligation in our programs and our campuses, of course, is to provide consistent, honest, factual, up-to-date information. That is the first message I hope we will give.

Second, in our AIDS education programs on college campuses, if they are to be effective, they must lead to changes in behavior. Those of us involved in AIDS education must focus on this important fact. Information is needed, of course, but we must urge students to deal openly with a topic which our culture still finds socially uncomfortable our sexual behavior.

Until we are able to get our students to talk frankly and honestly with each other about their sexual practices, we probably will not make a very important impact with our campus AIDS education programs. The most encouraging part of our peer facilitator participation is that they have been reasonably successful in getting students to talk with each other.

The third message: Bigotry in any form cannot be tolerated on our campuses. This is a very important message that the campus AIDS education program must transmit. It will serve no one's purpose to ridicule, judge or exclude members of some group because of their sexual preferences or their needle-sharing practices. A successful AIDS education program requires a genuine, caring, non-judgmental concern for people. If this tolerant, accepting attitude is not present, it will be quickly sensed by those who need it most and the educational program will be for naught.

Perhaps most importantly, the campus AIDS education program must convey a sense of compassion. This must be reflected in all of the activities and attitudes of the people involved, from student peer facilitators, residence hall staff and counselors to student affairs administrators, health professionals and the campus president. The stakes in this battle are much more serious than any other that we have faced and the educational effort of our colleges and universities on the AIDS problem should bring out the very best of us as human beings. Thank you.

DR. CRENSHAW: Dr. Keeling.

DR. KEELING: Dr. Crenshaw, Members of the Commission, I am troubled by the fairly dismal assessment of our young people that we have been hearing today. As someone working on a college campus, I would present an alternative view. I actually

have considerable confidence in the future of our young people. I have a great deal of respect for the energy and commitment of people like the two sitting on my left and I have a lot of hope for the future that is in their hands. I would like to distill the comments I made to you in my written testimony into ten recommendations concerning AIDS education on college campuses.

First, I hope you will recommend and promote the development of those educational programs. Dr. Watkins asked that I comment in my testimony about reasons for our concern about the spread of HIV among college students and I will do so briefly.

The first of those concerns can be summarized as a series of developmental issues. I don't really see college students as the hedonistic, uncaring, self-absorbed people portrayed earlier today. Rather, I see them simply as people going through the same developmental processes that you and I did when we were their age.

I think that cognitive and moral development in college students occur in settings of struggles to achieve autonomy and responsibility; in settings that allow and encourage experimental behavior. The same rejection of risk which encourages drunk driving, use of alcohol and drugs, and staying up all night the night before the final exams will encourage unsafe sexual contacts.

In campus environments, the development of autonomy and identity occur in contexts that stretch all boundaries of thought and action. People are often away from home for the first time. We often see them, therefore, put in situations of relatively great vulnerability to HIV infection.

Many students have difficulty acknowledging or planning for sexual activity, especially when parental or societal standards forbid it. Many don't know what they want out of sex, don't know where sex fits into their priorities, and have not systematically separated their values from those of others. It may be so difficult for them to acknowledge sexual behavior that experimental sexual encounters will be furtive and unacknowledged and, therefore, very often unprotected.

In addition, students will often use alcohol or recreational drugs as a cover, which allows them to avoid responsibility for sexual activity or as a way to promote sexual activity in someone else. Acquaintance rape is a serious problem on college campuses. In the situation of acquaintance rape, precautions are seldom, if ever, taken.

Many students have not developed the self-esteem, self-confidence, or assertiveness to make good decisions, to

postpone sexual activity, to demand safer sexual behaviors, or to insist on the use of condoms, if they are having sexual intercourse.

Complicating all of this is the fact that many of our students arrive in college with a relatively fragile sense of values. What indirect and inconsistent messages they may receive from parents or others are often diluted by the strong influence of peer pressure, what they see in the public media, what they read in advertising. The relativity of values which is inherent in a series of revelations about the personal behavior of television evangelists or presidential candidates contributes to a cynicism about morality in general and to a distrust of restrictions suggested by people in authority.

Beyond these developmental considerations about sexual behavior are similar issues related to experimental use of drugs, which on college campuses is more often occasional and experimental than it is addictive and consistent.

Reinforcing these developmental concerns is the experience of college health centers, which tells us repeatedly that students are commonly sexually active and that they are rarely predictable or consistent in their use of measures to prevent pregnancy or sexually transmitted disease. We know that as much as 25 percent of the clinical case load in many student health services is made up directly of problems related to sexual behavior or unprotected sexual contacts.

For all of these reasons then, we have both theoretical and experiential concern about the possibility of transmission of HIV among college students. Therefore, our first recommendation is to promote the development of effective eduation programs.

Our second recommendation: we hope that you will encourage and endorse those education/prevention programs on <u>all</u> college campuses. Dr. Watkins asked that I address barriers to effective AIDS education. One is the obstacle of opposition from other people looking at these programs and concerned about the terminology, the concepts, the vocabulary, or the imagery.

Sometimes people deny that AIDS can happen "here." They think it is "somebody else's problem." The endorsement of a prestigious national panel would lend relevance and credibility to the implementation of these programs in institutions, which have thus far been reluctant. It will be helpful to work through national organizations to set guidelines and standards for these programs.

A third recommendation is that you assist colleges and universities in organizing and implementing these programs

through training educators and counselors. Another barrier to providing AIDS education is not just reluctance, but inadequacy of numbers of educators or counselors or amounts of funds to train and prepare them for the work they have to do.

Training grants, regional workshops, institutes sponsored through the American College Health Association, (as is now done through our cooperative agreement with the Centers for Disease Control,) will help. More of those initiatives are needed to build skill and expertise in specific issues of college and university AIDS prevention.

Let me emphasize in response to a question asked in the previous panel that these training programs have been carried on for more than three years without federal assistance prior to the development of the cooperative agreements, through volunteer work, through the contribution of people in national organizations and higher education and the support of individual schools.

Our fourth recommendation is that you encourage the development of explicit and effective sexuality and sexually transmitted disease education programs in higher education prior to college. The fact is that many of our students arrive on our college campuses imperfectly prepared to deal with the issues that face them when they get there. Parents and, sometimes, school systems have been unable or unwilling to provide accurate, sensible and comprehensive information. Often the programs have been quite watered down. Sometimes people fear that explicit language will convert good kids into bad ones and the result for us is that many of our students arrive in our residence halls with incomplete and sometimes distorted knowledge about sexuality, contraception and sexually transmitted disease.

Our fifth recommendation is that we hope you will provide resources for research into effective educational strategies by funding demonstration projects and teaching models that address the specific vulnerabilities of college and university students. These good educational programs, we think, will work with and through the developmental conflicts we have addressed. They will emphasize skills building, negotiation, and good decision-making. They will work to develop community consensus of safer behavior and safer decisions. They will emphasize the development of self-esteem.

We believe in the American College Health Association and on college campuses that the most important weapon our students have in protecting themselves against infection with HIV is self-respect and self-esteem. The message we deliver must be one of valuation and we must find ways to encourage self-esteem if we are going to hope to prevent HIV infection.

Messages of self esteem should be for male and female students, gay and straight students, white and minority students. The fact is that if we continue to tell our students that they are hedonistic and self-absorbed, or if we tell our black students that they are second rate, or if we tell our gay students that all they do or are is wrong, we have no hope of their regarding themselves with enough value to take the precautions that will protect them from HIV infection.

Our sixth recommendation is that you support basic behavioral, social, and psychological research into educational approaches which overcome the resistance inherent in the sense of invulnerability and invincibility among students in this group. We believe many of those projects will center in the development of self-esteem.

Seventh, we hope you will assist colleges and universities in the development of resources and materials which are explicit and helpful. The common admonition of AIDS education for young people, "don't share body fluids," is confusing. What fluids are we talking about? What exactly does "share" mean? A society that launders and sanitizes words, replaces unpleasant images with euphemisms, and romanticizes them with substitutes will promote the same mythological thinking that has allowed some students to believe you cannot conceive pregnancy if intercourse occurs with both parties standing up.

Eighth, we hope you support the development and implementation of education programs which specifically address the different and important issues of a rich diversity of students on our campuses. Programs which work for inner city schools will be different than those that work on residential campuses. Programs which work for Latino students in some areas may not work for Latinos in others.

We need to address the needs of black students when they are in the majority and when they are in the minority on the college campus. Materials for gay students must be cautious that our teaching about male to male sexuality does not stigmatize gay men nor blame them for this epidemic.

Ninth, I hope you will support the development of a variety of education models are integrated into a diversity of other campus activities. These AIDS education programs, if they function as part of the ordinary process of life in an institution, will provide more success and less risk. They can be provided through campus ministers, through counselors, through the local Red Cross blood centers, through resident advisors in residence halls, through athletic trainers, through international student centers and advisers and through the peer education programs that you will hear about in just a moment. Organizations representing and working with those individuals

may be involved in AIDS education through the model of the cooperative agreements that we have seen. Multiplying of resources will allow us to reach a large number of students with the expenditure of relatively small numbers of funds.

Finally, our tenth recommendation: we hope you will support carefully-designed and sensitively-conducted seroprevalence studies to estimate the incidence of HIV infection among college students and to monitor trends in infection over time such that we will have baseline data on which to base educational strategies and on which to target our interventions.

Those are our recommendations. Thank you very much.

DR. CRENSHAW: Thank you.

Mr. Kellar.

MR. KELLER: Thank you.

I am a third year architecture student at the University of Virginia and have been a peer sexuality educator for two years now and I wanted to describe to you who we are as peer sexuality educators and what we do at the university.

First of all, we are not medically-trained experts. Rather, we are specially-trained students. We are trained in the area of contraception, sexually transmitted diseases, sexual lifestyle issues and pelvic exam procedure.

Our activities include dorm talks where we go to the first year dorms at the university and discuss with the first year students contraception. We bring a bag of a condom, diaphragm, spermacide, to show first year students. We discuss sexually transmitted diseases and then we generally go into a discussion about sexual lifestyle issues.

Very often we talk about date rape and we talk about AIDS. Those are the two big areas where we get all the questions.

We hand out our safer sex packet, which we have put together, which include a condom and information on sexually transmitted diseases and contraception. We publish a booklet called "Ounce of Prevention," which has extensive information on contraception, sexually transmitted diseases, is edited by, among others, Dr. Keeling, and that is also handed out at the dorm talks.

Each peer sexuality educator has office hours at Student Health, where we see students who come in. They either

make an appointment or they call us. Usually we have a lot of females coming in for their first pelvic exam and we tell them, first of all, what they should expect. We also get a lot of students coming in wanting to know about birth control.

Usually, if someone comes in thinking they have a sexually transmitted disease, we refer them to a medical expert.

We co-sponsor an annual condom awareness day at the university. We co-sponsor it with the Lesbian and Gay Student Union. This has achieved somewhat legendary status at the university. A lot of people look forward to it with anticipation, ourselves included. At this event, we hand out condoms and information on birth control and sexually transmitted diseases.

We have an outreach program where we go out -- number one, to train a group called Madison Health Hotline. They man a hotline at the university, which anyone can call. It is a kind of general, all-purpose, depression, trouble, problem hotline and we train them in our area of expertise.

Once in awhile we will get a request from a social organization, such as a fraternity or a sorority, for us to discuss with them -- usually they want to know about sexually transmitted diseases, specifically AIDS, and other sexual lifestyle issues.

Finally, all of our literature is kept, as well as at Student Health, at a place -- at our main student activity building, called the Wellness Center, a type of self-diagnostic treatment center, where all the literature, all of our materials, are easy to reach by the students.

DR. CRENSHAW: Thank you very much, Mr. Keller.

Ms. Flickinger.

MS. FLICKINGER: I am Laura Flickinger. I am a fourth year English major and the chairperson of peer sexuality education at the University of Virginia. I got involved with the program in my first year because I was interested in getting some counseling experience and also because I saw a need at UVA for peer education.

I think college students find it a lot easier to talk about sensitive issues, like sexuality, with a trained peer, rather than having to talk with a doctor, nurse or some other type of authority figure.

Being a peer sexually educator has been extremely rewarding for me. For example, many women come into the office for their first peliv exams extremely nervous and upset. I just

sit down with them and go over the procedure and talk out their fears a bit. It is really, rewarding to see them leave the room looking very much relieved. In addition, I have friends who call GYN and ask to talk to me in particular. I find that very satisfying as well.

Also, I gave a talk in my sorority a couple of months ago, which went really well. We generated a lot of discussion. In fact, we discussed the talk for weeks afterwards. It appeared that everyone came away well-informed and that the material made them think. It was very successful.

One thing I want to talk about today is our training. I don't want you to think that we go and impart all this information to students without having been adequately prepared. The training is extensive. It is 30 hours long and it requires that we read and attend lectures about anatomy and physiology, birth control, sexually transmitted disease, group facilitation, communication skills and the emotional, identity and developmental issues of sexuality. Thus, we are very well prepared.

In addition, all new PSEs must complete a mock session before they can be allowed to counsel. It is just a role play in which one potential PSE will play the client and the other will be the PSE and they will go through a session in front of an old PSE. The PSE will give the role players feedback and let them know if they are prepared well enough to actually be counseling other students.

Another good thing about the program, besides the fact that we are well-trained, is that the group itself is very diverse. Of the 25 members, we have students from all walks of life, with males and females, blacks, whites, homosexuals, RAs, people from all the different schools at UVA. Also, the personalities of the people who are in the group are fantastic. Everyone is very open and they enjoy their jobs. They really care about the students to whom they are talking.

Student reception to the program has been enthusiastic. We give evaluations to all the students who come into the office and 95 percent of those come back rating the PSEs as excellent. That is also reflected in the dorm talks, which Mr. Keller talked about before, where two or three PSEs will go into the first year dorms and discuss issues like birth control, sexually transmitted disease and values. Those students are very enthusiastic and a lot of good discussion gets going.

One thing we find from the evaluations from the dorm talks is that these students really do need the information. They say that they have had sex education in high school, but

also that they learned something new at the talks, which reflects that either we are going into more depth or covering different issues than they learned in high school. So, they are getting information that they truly need.

In conclusion, I would like to say that I think the program benefits everyone involved, both the people who are in the program as PSEs and also the students who are receiving the education. And I would be extremely happy if, as a Commission, you would support peer education on college campuses. Thank you.

DR. CRENSHAW: Thank you.

Let's begin the questions with Dr. Walsh.

DR. WALSH: Thank you, Dr. Crenshaw.

We are always into the essence of the success of education as behavioral modification. We have heard varied opinions about if you don't get them in kindergarten, you don't get them at all on up through, different age groups, each feeling strongly about what they believe.

One question is by the time a young man or woman gets to college in this generation, is behavioral modification still on fertile soil? I mean, is there something that you are able to do in bringing about behavioral modification, whether it be in substance abuse, alcohol, sex habits? Is your counseling and your support primarily supportive by that time rather than able to achieve any behavioral modification? All or any of you.

DR. SANDEEN: I suspect you are going to hear responses from a biased group. I have spent my career with college students, so I believe that the college years represent an important stage where developmental education takes place. I am speaking now primarily with the 18 to 22 year old group of college students. Of course, there are many much older than that, as well. But there is a good deal of research to indicate that students, in fact, do change during those years in terms of their attitudes, their values, and the ways they choose to spend their lives. And much of the education that we are involved in with students is directed at those issues. So my response very clearly is "yes," we do believe that students during these years can change. That is one of our important responsibilities, to assist them in that process.

DR. KEELING: I would agree with Art Sandeen. I think that the whole process of what we talk about in student affairs in a college setting we call of student development and the use of that term, I think, implies very correctly that these young people are still not just fertile but wonderfully fertile for development and advancement and change.

I think that sometimes our perception that we fail to do that is based more on the failure of our methods than it is on the fertility of the soil.

MR. KELLER: There is a lot of pressure in college by the freshman year to have a basic knowledge of birth control, of sexually transmitted diseases so that -- at least in the company of their peers, when we walk into a dorm, we run the risk of being redundant and we don't get a lot of response from discussing birth control. We get some response from sexually transmitted diseases and we get a lot of response from AIDS and other issues, such as date rape.

We do find, however, that there are a lot of basic facts about sexuality that slip through the cracks and we find that when we talk to people in the office hours. People come to us and it is really rewarding to tell someone something that is second nature to you, that they have just never really understood or never even knew. So, I think there is a lot of room for expansion in college.

MS. FLICKINGER: I would definitely agree. I think that sometimes students don't listen to information. It kind of goes in one ear and out the other until they really get themselves into a situation where the information is going to do them some good. It is when students have need of information that it is nice that we are available because they can come and ask us. There is definitely room for change because students are changing constantly.

DR. WALSH: I think you implied as much, Mr. Keller, as a counselor and a college student, or close to that level, you have been surprised, perhaps, at the lack of sophistication of some of your classmates by the time they get to college or do you find them fairly knowledgeable, despite what apparently is a lack of health education, in secondary schools or lower?

MR. KELLER: No. I find them, on a whole, very --

DR. WALSH: Very sophisticated.

MR. KELLER: -- sophisticated, very well-versed in sexuality. What I was trying to get across is that that kind of breeds an atmosphere where if you don't know certain basic facts, it is difficult to ask in some settings. So, when they do come to us, it is about some -- generally, it is a small thing, well, to us, but to them it can mean a world of difference.

DR. WALSH: Now, my last question is we have seen a great deal about behavioral modification and heard a great deal about behavioral modification among the gay community. I think

that has been primarily among the so-called mature gay community, in the major cities, where they have done a very fine job of education. Do you notice any difference or any trend or any change in the behavior of homosexuals at the college age. Do you see that many homosexuals at college age that are not having behavioral modification in their sexual habits?

MR. KELLER: We do see a lot of homosexuals. We are -- I personally have not talked to that many. It is hard from my perspective to grasp the change. What I see in the gay community is a lot of change toward having fewer sexual partners, a definite awareness of ways to prevent catching a sexually transmitted disease, a definite awareness that they are in a high risk group.

DR. WALSH: No, it is good because I was curious as to whether the education that has been offered by the gay men's groups has reached down to that level. We know it has reached the more adult group. Have you had experience with that?

DR. KEELING: Let me just comment from the point of view of a health service. By the evidence we see in either patterns of immunization to Hepatitis B, which is strongly recommended for our gay students or by rates of sexually transmitted diseases in our gay population, we see extraordinary evidence of responsibility.

The rates of sexually transmitted diseases among our gay students are now much lower than rates of sexually transmitted disease among students in general.

DR. WALSH: Both homosexual and bisexual students?

DR. KEELING: Right.

DR. WALSH: Good.

DR. KEELING: And what we find, I think, would validate everything that Andy said and that what we see medically verifies the social observations he makes.

DR. SANDEEN: If I can make a brief comment on that, it has only been in about the last 15 years, at least in my experience in the Midwest and in Florida, that some of our gay student organizations on college campuses have, in effect, come out as student organizations and have participated in campus life openly, in student government activities and the like.

Since the AIDS problem has been with us, many of us on college campuses have seen these gay student organizations become much less visible. So, those of us engaged in AIDS

education efforts, in order to reach those students, have had to make special efforts to assist them to feel more comfortable on the campus, not only as individuals but as organizations. We feel that is an important component of the efforts that we are engaged in now.

DR. WALSH: Thank you.

DR. CRENSHAW: Ms. Welch.

DR. CONWAY-WELCH: Dr. Sandeen, a brief question. Do you see the interest on college campuses now in terms of education about sexuality in general and HIV in particular coming out of a groundswell of student interest to which administrators respond or is it administrative interest which is sort of imposed on -- not imposed, but comes down from above down to the students in the sense that they should be interested in it?

DR. SANDEEN: I think there is probably some of both, but as you know, as a health professional, there is great interest in health, fitness, wellness throughout our society and perhaps among our college age youth, in particular.

On the other hand, specifically on the AIDS issue, at least on our campus at the University of Florida, the initiative, began with us as administrators, but we quickly found, as we find with all other activities, where we are trying to have some impact upon our students, we must involve student organizations throughout the campus, and faculty. So, it quickly became a joint effort and now our students are very active supporters.

DR. CONWAY-WELCH: Thank you.

DR. KEELING: Dr. Welch, if I could add, in the process of my work in the past three years, I have, as of yesterday, been to 186 college campuses, doing AIDS education work. About 20 percent of the time I actually am brought in by student groups themselves, as opposed to by the campus administration. There is a pleasing diversity of those groups, sometimes from sororities to lesbian/gay student groups to peer sexuality education groups to sometimes just coalitions of black students or others, who want to learn.

I think that some of the most impressive AIDS education programs we have had on our college campuses have actually developed at grass roots level by students themselves and have required and eventually sought assistance from us in student affairs to work with them.

DR. CONWAY-WELCH: Thank you.

DR. CRENSHAW: Thank you --

MS. FLICKINGER: I wanted to add that I talked to a friend the other day, who is a chairperson of peer sexuality education at the University of Pennsylvania, and she said that -- they are having a big problem getting it started because there is a lack of interest from the administration.

DR. CRENSHAW: Thank you. Thank you, Dr. Welch.

Ms. Gebbie.

MS. GEBBIE: I have some sense that we may have been hearing described today sort of the cream of the program; that is, a rather comprehensive and well-structured one and we have heard something about the level of interest in other colleges, but if you -- sort of like the question that was asked of the previous panel, if you had to rate in general colleges across the country, are more than half of them well up into the kind of program we have been hearing described this afternoon or 5 or 10 percent or are some of them still absolutely terrified of this kind of open acknowledgment of the sexuality of their students?

DR. KEELING: We have some anecdotal information about that and some survey information. The American Council on Education this past May surveyed institutions to seek whether they had AIDS policies or AIDS education programs. They found an overall rate of only 19 percent of American colleges and universities then operating such programs or having such policies.

Within that 19 percent, however, were some distinctions which are important. Institutions which had baccalaureate programs had lower rates than those with master's or doctorate programs and as you reached universities with more comprehensive educational programs, the likelihood of having an AIDS education program or policy did surpass 50 percent.

I think what we have seen in the past six or eight months is some improvement in those numbers, but the cooperative agreement between our association and the CDC was expressly developed to try to raise those numbers and improve the numbers of schools providing AIDS education programs. I would estimate now maybe 30 percent or a third of all institutions providing them. Many of the ones which are do are smaller, commuter, community colleges or two year schools, which have fewer resources and fewer people, less access to a "captive population" for an educational programs.

DR. CRENSHAW: Thank you. Dr. Lilly.

DR. LILLY: Just a quick question --

DR. CRENSHAW: Hold it. Do you have --

MS. GEBBIE: I have another question.

One of the things that has been suggested to me by a faculty member of a university is that in addition to this kind of very specific service and the student health-related things on AIDS and the biology-oriented approach to AIDS, that colleges and universities could contribute to our total social understanding of this epidemic through an academic exploration of the epidemic from a broader base in interdisciplinary courses, in which ethicists, sociologists, historians might join with biologists to look at what is going on and interpret some of what we are experiencing here to aid the society.

Is that something that has been talked about that you are familiar with in any way or what kind of comment would you have on that?

DR. KEELING: It has and there have been some experimental programs developed. Interestingly, several of them, which have been most creative, have been developed in schools or colleges of nursing as parts of universities, in which nursing professionals have brought together the skills of people from the medical school, other academic areas, sociology, anthropology, biology, psychology, to put together comprehensive courses on AIDS.

The one through our nursing school at the University of Virginia, for example, is simply called "AIDS: Beyond the Medical Issues." There is attention to the medical issue for the first couple of weeks, but the remaining 16 weeks of the course deal with everything from ethics and philosophy to public policy to law, et cetera. That is mirrored in other attempts to integrate information about AIDS into class curricula through courses. Some of the most important and helpful experiences that many of us doing campus AIDS education have are those of going into a lecture class, doing a couple of guest lectures about AIDS and then participating in the discussions that follow.

DR. CRENSHAW: Dr. Lilly.

DR. LILLY: Just a quick question out of curiosity. Mr. Keller, you used twice the phrase "lifestyle." What did you mean by that phrase?

MR. KELLER: We use that phrase to encompass the types of issues that we discuss. Like I said, date rape is a large issue and --

DR. LILLY: As a lifestyle?

MR. KELLER: No, but it is something to acknowledge during your lifetime. We also -- that refers to people coming in to our office hours discussing sexual dysfunction, homosexuality --

DR. LILLY: I just wondered. Thank you.

DR. CRENSHAW: Dr. Lee

DR. LEE: When we are talking to this group, we are talking to the cream of the crop and there is a problem that we have in the AIDS game, that most of the people that are getting AIDS are not college graduates. They don't have educated parents. They don't have intact families. That is what sort of brought AIDS to -- well, excuse me -- it happens, but it is tremendously in disproportion with the people in the disadvantaged homes, et cetera.

They drop out of college; they drop out of high school; they drop out of grade school. You people on the right are very valued in helping your peers. I know at Yale, my alma mater, there is an awful lot of activity in the community, New Haven. Do you try to interact with your local communities and in the cities where you operate because that is where a tremendous percentage of the problem lies?

DR. SANDEEN: I appreciate that question because, as Dr. Keeling said earlier, he is very high about college students and the positive things that characterize their lives these days. I share that view and there is a move now on many campuses throughout the country back to volunteerism by students in the very best sense of that word. An organization called Campus Compact, through the Education Commission of the States, now is on well over a hundred campuses, specifically recruiting students to engage in community service activities.

We now have a volunteer center on our campus and while we are not located in a large, urban area -- we only have a hundred thousand people in our city -- there are obvious needs there that perhaps our students can contribute to related to this problem.

I think that opens up an important area of responsibility that we can help teach our students while they are in college because it is one of the responsibilities that they have as college educated people.

DR. KEELING: Let me add that I think in teaching and working with the very gifted people whom we have the real privilege to deal with in our work, that we are dealing with people from whom will come leadership in the future; leadership

in programs and policy, leadership in society and ethics and I think that what we do with our college students will be almost endlessly multiplied in what they will do after they leave us. The investment we make in them, even to the extent that some of them would not have allowed themselves to be at risk anyway, will be greatly rewarded in what they will do for others who might be more at risk.

I would also say that as a physician, who does care for patients with AIDS, that at least 80 percent of the people with AIDS I have cared for and buried have had college degrees. I think that we wouldn't want to create the impression that people who did have college degrees were any less at risk than people who didn't.

MR. KELLER: I would like to say that we have our hands full at the University of Virginia in the things that we do and if we were to go out into the community, it would take an expansion of our organization.

DR. KEELING: I might just mention one other little piece of that, though. We have at one level beyond college, in the professional school level, we have medical students at the University of Virginia, who are performing AIDS education service in the high school systems in the communities in which they live. They take what is basically the limited off-time that they have to go work with high school students towards better AIDS education. Similar programs among graduate and undergraduate nursing students from our institution -- and Art is nodding his head, I suspect from others that he knows of as well.

DR. LEE: One of the main reasons I am trying to put this to you, though, is if I talk to a 14 or a 16 year old and he is a person who is not my child, they would think of me at the present time as ancient history. They are going to look at this gentleman as history and they are going to look at him as, okay, maybe we have to listen. For them, you two people are gods. You are in your early twenties. You know all the answers and you are simply gods to a 14 or 15 year old kid.

In the local communities, as has been stressed here, self-esteem and self-worth, when you are a young person, is the whole of the game and you can spot instantly the person in the group that knows what he is doing, knows where he is going. The other students just gravitate to him. That is why a gentleman like this, I know, would be very successful. They are going to go right for him. He has a feel for it. You people have a terrific role to play with these kids. An awful lot of the people going into drugs have no self-esteem whatsoever. I mean, that has been the testimony that comes out endlessly on this and the peers in your age group are everything. So, I am trying to

tell you what power you have and I hope that you will be encouraged to use it.

DR. CRENSHAW: Dr. Keeling, you mentioned the quest for some baseline surveillance data that could be followed over time in the college students. Do you think there is a role for testing among college students, voluntary testing, and, if so, are the facilities readily available to the students?

DR. KEELING: I think we have a couple of different possibilities here. I think what we need first is an absolutely blinded series of studies to try to answer the very basic question of prevalence of infection. Once we know that data, it may be appropriate to subdivide and refine the study to try to define risk factors or define areas of infection or try to focus our educational programs on the basis of that data.

When you get to those levels of study that may require voluntary consent, as opposed to a blinded study. In addition, I would add that many college health services now provide counseling and testing services for HIV antibody. There are a number of college health services, which provide truly anonymous testing. The majority of good college health centers which have laboratory capability provide either their own drawing of blood for antibody testing service or referral to an immediately accessible community clinic for it.

In all of these situations, I think the health services accept their responsibility to provide the pre-test counseling and the post-counseling and support, which are inherent in any good testing programs. So, I think there is room for both research level testing to help us define our needs better and for voluntary available testing for students, who want to assess their own risk of infection or to answer the questions they need to know.

DR. CRENSHAW: Thank you.

Dr. SerVaas, did you have any questions? No. Okay.

I want to thank you so much. It is really a pleasure at the end of the day to hear an encouraging and uplifting message because I happen to believe in our kids, too, and I think that they are capable of teaching us a few things. So, thank you for your thoughtfulness and for your encouraging words and at this point I would like to turn the meeting back over to the Admiral.

CHAIRMAN WATKINS: Thank you very much, panel members. I apologize for not having been here for a majority of your discussions. I did hear Dr. Sandeen talk about the Campus Compact, which I think is one of the bright hopes. We have to begin the movement of community service among youth in the

nation. We need them desperately to help other youth. We need them in many other ways. And the work you are doing at Brown University and other universities is really heartening. It will probably be the embreyo of a movement in this nation to move much more aggressively.

We are going to need that baccalaureate level experience and push to get help in the nation. We all know the numbers. We need 3 1/2 million young people helping us right now. So, we can use that movement and it is an inspiration to hear that you are enthusiastic about it.

Thank you very much. We are going to adjourn the formal hearings on education at this point and we are going to reconvene the Commission in Executive Session at this point. I call all the Members of the Commission up now for Executive Session.

(Whereupon, at 5:33 p.m., the open session of the hearing was adjourned.)