THE PRESIDENTIAL COMMISSION
on the
HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC

HEARING ON Western States Response

March 24-25, 1988

August 24, 1988

TO OUR READERS:

The Presidential Commission on the HIV Epidemic held over 45 days of hearings and site visits in preparation for our final report to the President submitted on June 27, 1988. On behalf of the Commission, we hope you will find the contents of this document as helpful in your endeavors as we found it valuable in ours. We wish to thank the hundreds of witnesses and special friends of the Commission who helped us successfully complete these hearings. Many people generously devoted their volunteer time in these efforts, particularly in setting up our site visits, and we want to fully acknowledge their work.

The staff of the Presidential Commission worked around the clock, seven days a week to prepare and coordinate the hearings and finally to edit the transcripts, all the while keeping up with our demanding schedule as well as their other work. In that regard, for this Hearing on Western States Response, we would like to acknowledge the special work of Peggy Dufour, along with Jane West, Elizabeth Paul, Frank Hagan, Philip Strobel, and Victoria Thornton in putting together the hearing, and Peggy Dufour and Macy Moy, in editing the transcript so it is readable.

For the really devoted reader, further background information on these hearings is available in the Commission files, as well as the briefing books given to all Commissioners before each hearing. These can be obtained from the National Archives and Records Administration, Washington, D.C. 20408.

One last note--We were only able to print these hearings due to the gracious and tremendous courtesies extended by Secretary Bowen's Executive Office, especially Dolores Klopfer and her staff, Reginald Andrews, Sandra Eubanks and Phyllis Noble.

Sincerely,

Polly L. Gault
Polly L. Gault
Executive Director

Gloria B. Smith
Gloria B. Smith
Administrative Officer

PRESIDENTIAL COMMISSION ON THE
HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC

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PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC

HEARING ON THE WESTERN STATES RESPONSE

The Hearing was held at the
San Francisco Department of Public Health
101 Grove Street, Room 300
San Francisco, California

Thursday, March 24, 1988

COMMISSION MEMBERS PRESENT:

ADMIRAL JAMES D. WATKINS (Ret.), CHAIRMAN

KRISTINE M. GEBBIE, R.N., M.N.

FRANK LILLY, PH.D.

BENY J. PRIMM, M.D.

CORY SERVAAS, M.D.

WILLIAM B. WALSH, M.D.

POLLY L. GAULT, EXECUTIVE DIRECTOR

COMMISSION MEMBERS NOT ATTENDING:

COLLEEN CONWAY-WELCH, PH.D.

JOHN J. CREEDON

RICHARD M. DEVOS

PENNY PULLEN

I-N-D-E-X-

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WELCOME

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SPECIAL POPULATIONS

PANEL TWO

WEST COAST ORGANIZATIONS

INDIVIDUAL TESTIMONY

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PANEL THREE

CORPORATE RESPONSE TO AIDS

PROCEEDINGS

MS. GAULT: Distinguished guests, members of the Presidential Commission, my name is Polly Gault, and I am the designated federal official, and in that capacity it is my privilege to declare this meeting open. Mr. Chairman?

CHAIRMAN WATKINS: Good morning, today the Commission begins two days of hearings and site visits in San Francisco, a city closely identified with a positive and successful response to the HIV epidemic. This past September, three members of our Commission visited the city, and we are now pleased to return as a full Commission for official hearings. During the coming two-day period we will be hearing testimony from community-based organizations from San Francisco and five western states. In addition, corporations that have developed model AIDS in the workplace policies and from health policy makers and mayors from three major California cities. The Commission has for some time looked forward to coming to San Francisco and would like to express its gratitude to those organizations and individuals who have helped to make these hearings and site visits possible. We extend our special thanks to Mr. Alan Harris of the US Public Health Service and Ms. Ann Schlegel of the San Francisco Department of Public Health, and we would, also, like to thank Dr. David Werdegar for allowing us to use these facilities for our hearings.

We planned to have hanging here today a panel from the memorial quilt created by the Names Project here in San Francisco. However, the hearing room would not accommodate the quilt, so I understand the quilt will be sent to us in Washington, D.C. for a later hearing. The Commission appreciates the special attention that was planned for our hearing.

Senator Pete Wilson, also, asked that I mention that available to you all and to the press was his statement on occasion of these hearings today and without objection from the members of the Commission, I would like to enter that statement in the official record. So, those of you who would like to get his statement on the actions that he is currently taking with his special interest in the AIDS epidemic, I suggest that you pick up copies at the back of the room.

Our first group of witnesses this morning consists of representatives from community-based organizations serving special populations primarily in the San Francisco community, and with us on our first panel is Dr. Davis Ja, Executive Director, Asian AIDS Project, San Franciso, Lillis Stephens, Chair, Hemophilia Council of California, Sacramento, Dr. Concha J. Saucedo, Executive Director, Institute Familiar de la Raza, Inc., Latino AIDS Project, San Francisco and Philip Tingley, Director of Social Services, Corporation for American Indian Development, San Francisco. We also have with us Dr. Amanda

Houston-Hamilton, Chair, Black Coalition on AIDS, San Francisco. Welcome to all the panelists this morning, and we would like to open the session then with the statement by Dr. Ja.

DR. JA.: Mr. Chairman, members of the Commission, guests, first of all, I would like to thank the Commission for the opportunity of making a presentation today. I realize I am, also, going to be the only Asian making a presentation before the Commission in this proceedings.

The Asian AIDS Project began early last year following two years of advocating for AIDS services to the Asian community. Prior to that time we were not considered a priority, given the comparatively low rates of Asians with AIDS, despite the fact that we have been experiencing an increasing incidence of Asians with AIDS in the last three years.

We were finally funded both the city and county and the state of California last year to provide health education, prevention, training and education to the San Francisco Asian community. Currently our project has a budget of $230,000 a year and a staff of six. We are still the only Asian-specific program in the United States providing these services to our community.

The bulk of our activities lie in AIDS education. We are targeting major Asian ethnic groups, including Filipino, Chinese and Japanese, Korean and Vietnamese communities. Our educational activities include presentation workshops, mass media approaches, brochure development and distribution. In addition to educating the lay public, we also train Asian health and human service professionals and community leaders.

To date in our community, we have few statistics regarding the knowledge, attitudes and risk behavior surrounding AIDS in our community. Yet, this information is vital in order for us to effectively educate the community.

In order to meet this need, we have conducted and will conduct several need assessments and research projects. In 1986-87, we conducted focus groups with Chinese, Japanese, Korean and Filipino communities to determine the best method of measuring and understanding the attitudes and knowledge base of our community. We are now applying for proposals to conduct baseline surveys in order for us to determine the extent of the awareness of the AIDS epidemic in these communities.

Currently we are also conducting a survey of Asian gay and bisexuals funded by the Center for AIDS Prevention Studies to provide information vital to our program planning around the Asian gay community. Besides providing education in and assessing the needs of our community we are, also, organizing an extensive Asian task force with a total membership of over 300 individuals concerned about the AIDS epidemic. This is in San Francisco. The most difficult aspects of our efforts to educate the community lie in our heterogeneity. One of our problems is the fact that there are 32 distinct Asian groups. We have different languages. We have different attitudes, traditions and customs and behaviors.

The methods and processes by which we can reach these distinct communities are extremely different and difficult. This diversity is oftentimes overlooked, particularly in past program development AIDS education efforts, and it results in really inappropriate and inaccessible messages and services.

Additionally there are strong cultural stigmas regarding the AIDS epidemic, primarily because we have a great deal of difficulty in terms of discussing the issues of sexuality and discussing issues of terminal illnesses or homosexuality in our community. These are not topics we oftentimes talk about or discuss.

Given the fact that these are critical issues that we need to discuss with the AIDS issue, it provides us with an enormous task. We also fear there is widespread misconception regarding the disease throughout our community. AIDS is still considered a "gay white" disease, and this perception is certainly exacerbated by a great deal of homophobia that exists in our community.

What we need, clearly, is prevention education programs that are responsive to issues of cultural diversity in our community, particularly in language, attitudes, and culture. In addition, cultural barriers must be a primary consideration in combating this disease in our community. What we really need are resources and a recognition that this disease exists in our community as well. Thank you.

CHAIRMAN WATKINS: Thank you very much, Dr. Ja. Next we will hear from Dr. Amanda Houston-Hamilton, Chair, Black Coalition on AIDS, San Francisco.

DR. HOUSTON-HAMILTON: Thank you, Chairman Watkins. I would like to thank the Commission for the opportunity to speak with you today. The Black Coalition on AIDS has existed since early 1986, when Commissioner Naomi Gray, San Francisco Health Commissioner brought together black leaders from around the Bay area to discuss the impact of AIDS on our black community. From her perspective on the Commission she had seen spiraling funding for AIDS education and few activities directed towards the black population. Her invitation was a challenge to the black community to define and advocate for our own needs. Out of that challenge we have created a broadly-based grassroots organization, including over 200 individuals and agencies committed to the education and service needs of our community.

The aim of the Coalition is to ensure aggressive, culturally grounded education and service to the black community. However, we do not wish to become an education or service program. We have many programs within our community with that capability, and we have programs now that have been funded to do that. In contrast to Dr. Ja's program, we are a volunteer group of individuals. There is a similar organization within the Asian community and, also, within the Latino and Native American communities. Rather, we foster and support the expansion of the work already being done in community-based agencies to include a focus on HIV infection. Many of these organizations have the expertise to identify and intervene with specific persons at risk but have not had the awareness or technical skills to tackle AIDS up to now. We have worked for the inclusion of the needs of all persons at risk in ongoing city AIDS efforts, the elimination of institutional barriers to care, as racism, sexism and homophobia, for increased research on the course of HIV done by black researchers and other researchers of color and for the appropriate level of funding for indigenous programs for education and service delivery. Moreover the coalition has become a resource for the development of new strategies to combat AIDS among black Americans. Much of our activity has been advocacy.

The specific activities of the coalition are listed in my statement to you. I won't go over them. We began as administrators, researchers, ministers, health care professionals, health officials and have reached over time more broadly into the community. The independent volunteer-run organization now consists of gay and heterosexual members including people with AIDS, their families and loved ones.

With that expansion has come new concerns and direction for coalition efforts, and we find ourselves increasingly becoming a source of referral and information for people with AIDS and for those concerned about them in our community.

You will hear it said that massive homophobia and denial among black people is responsible for the poor success of efforts in our community. In fact, we are asking black heterosexuals to take on AIDS with all its phobias, and the black people of San Francisco, gay and straight have come together to struggle with this epidemic in a way unparalleled in the white community.

We bring several concerns to the Commission today. The first is to challenge the now popular notion that AIDS is a new issue in the black community. In fact, the earliest reports of the CDC included a substantial proportion of black and Latino gay men, and health anomalies were seen among IV drug users not long after.

Our community has simply been the last addressed, not the last infected. Similarly we must do away with the distinctions between the black population at risk and the so-called "general public." The subtle them/us racism and such typology only serves to feed avoidance in the black community. Nor should AIDS in minorities be considered a secondary issue as though there existed two diseases, AIDS and minority AIDS.

The media, as well as the public and professional educational forums isolate all discussions of people of color to a single program or workshop. Certainly important cultural economic and psychological issues distinguish AIDS in different communities, and these differences must be understood and utilized. However, the many peoples and cultures homogenized under the term "minority," can only be wholly served when their disease is viewed as an integral part of the AIDS American epidemic, not a side bar issue, nor should white America be assuaged by the sense that AIDS only affects others. Having said that, there are specific education service needs in our community. We believe that the most effective resources for outreach have been untapped. It is not true that black churches are an obstacle to our work. We regularly receive calls from clergy and church members asking to become involved. The process is slow, and everyone will not join the effort, but if taken on their own terms, they have much to give. Rather than belittle them, we must actively engage them at a national level as a source of credibility of man or should I say woman power and spiritual support in the black community.

Black people with AIDS tell us of their desire to be embraced by the church. It is a statement that they are not abandoned by the community. If we are to keep the cost of AIDS down, we must enlist the wonderful loving men and women who serve the church on a volunteer basis. A national initiative to effect this involvement is necessary. Other frontline workers must, also, be top priority for federal and local support. A centralized AIDS program will never be as effective in the black community as the funding of many small organizations dealing with drugs, alcohol, teens, women and children and sexually transmitted diseases. All the clever brochures in the world will not change behavior as does the personal contact with people we trust. These community programs already know the people, the needs, the language. They do not need sensitivity training. Funding and technical assistance will ultimately be the fastest, most effective and cheapest strategy. After all these organizations are the ones who will bear the brunt of the growing epidemic anyway and who are probably already seeing people with AIDS. Teen education is crucial to us. The data on STD's and drug use among black adolescents makes it clear that this population, our future is at risk and untouched. We feel AIDS is not just an IV problem; it is a drug problem. The sexual risk to non-IV women, for example is extremely high. They have more partners, riskier partners and do more unsafe sexual activity. They may trade sex for drugs with men who are IV drug users. Yet this largely cocaine and crack-using population considers itself outside of danger because they have heard needles are the transmission risk. The national initiative on drugs must be strengthened by the awareness of the connection of these two epidemics. However, the majority of black PWA's in San Francisco are gay or bisexual, as are the substantial number of those blacks infected across the country. We believe that these men have fallen between the cracks. They have remained underserved by gay and black programs. The incredible figures on knowledge and behavior change among gay men do not reflect the isolated black identified gay man. They do not receive the same education and service, and they are continuing to become infected at an alarming rate. In the haste to declare the epidemic over in the gay community, we must not forget these men who have been left behind.

Finally, we know from our involvement with service programs around the state that the black PWA represents new care management issues. They are dying alone, frequently only coming for medical services when they are too sick to walk, incontinent, demented.

They then require crisis care or intensive support and complex case management. We must have specific studies of the cost of care to minority people with AIDS because allocations now set probably are not sufficient to these needs. We must support active outreach to infected persons regardless of diagnosis to encourage early intervention and inclusion of family support. We must expand in-home services with Medicaid and other third party funding to keep the costs of treatment down and provide the ill and dying persons of our community with ongoing care and dignity. Thank you.

CHAIRMAN WATKINS: Thank you very much, Dr. Houston-Hamilton.

Ms. Stephens?

MS. STEPHENS: Mr. Chairman, members of the Presidential Commission on the HIV epidemic, invited presenters and guests, it is with great pleasure that I convey to you on behalf of the entire hemophilia community in California our appreciation for giving us this opportunity to address the concerns and delineate some of the issues and needs of this at-risk community.

The Hemophilia Council of California, a non-profit corporation, represents through its Board of Directors the four hemophilia organizations in this state. This consortium was founded in 1982, for the purpose of addressing the needs of the community on a statewide basis as opposed to the voluntary regional organizations which were and continue to be in existence.

In 1985, the Council received funding from the State Department of Health Services Office of AIDS, for the establishment of an AIDS education and risk reduction project in order to help prevent further infection in the hemophilia community throughout California, the first such statewide efforts of its kind. This project provides intensive preventive information and education to individuals with hemophilia, their partners, families and extended families. Education is, also, provided to health caregivers and to those other individuals who are at risk of HIV infection as a result of receiving blood transfusions and/or blood product derivatives. The Council has recently been successful in adding a psychosocial services component by an award of funding from the state department of mental health. This program enables the Council to provide much needed individual and family mental health counseling and support groups, crisis intervention, family planning, employment counseling, HIV testing referral, financial planning, discrimination and school issues, referrals to hemophilia treatment centers, hospice and residential care facilities, the clergy and a myriad of other outreach services.

The Council implements both the health education and psychosocial services programs through its regionally-staffed offices located in Oakland, Pasadena, San Diego and through its primary office in Sacramento. There is currently a health educator and a licensed professional counselor in each of these regional offices. The Council therefore stands as the only statewide direct services organization serving the varied and complex needs of the entire hemophilia community in California free of charge.

Our community is comprised of approximately 2300 individuals diagnosed as having hemophilia and at least 1600 being infected with the AIDS virus. This level of infection even surpasses the projected infection level of the gay and bisexual population which is stated to be nearly 50 percent in the most heavily impacted areas. We are a community that has long had to deal with a genetic disorder, that has been little understood, one that has had lifelong profound physical and psychological effects, one that not only affects the individual with the disease but the entire family. Even prior to AIDS, individuals with hemophilia had to endure discrimination and isolation from mainstream activities, were faced with a life expectancy that only reached early adulthood at best and had to endure physical pain and debilitation that was largely out of their control. Individuals with hemophilia may not expect longevity with comparable mainstream society, barring any significant complications of the disease itself, of which there are several, AIDS now being chief among them.

For brevity purposes, the term "hemophiliac" or individual with hemophilia hereinafter is intended to encompass those spouses and/or sexual partners of individuals with hemophilia who have developed ARC or AIDS or any perinatal cases of ARC and AIDS which may develop as a result of their sexual relationship. While it is not projected that these two subgroups will be represented in any significant numbers, the probability that these ARC and/or AIDS cases may present themselves needs to be noted. The Centers for Disease Control recently released an epidemiological report on HIV infection and pregnancies in sexual partners of HIV seropositive men with hemophilia. This report in a nationwide survey provided startling information concerning 2276 spouses or sexual partners of HIV seropositive hemophilic men. Of the third of the spouses and/or sexual partners known to have been tested for HIV 10 percent were reported to be seropositive.

Among all spouses or sexual partners, 12 percent were reported to be pregnant during the period of time which was reviewed. Of these pregnant partners who had been tested, 13 percent were positive for HIV prior to pregnancy. Sixty-five percent of the children born to seropositive women, also, have HIV positive tests. Based on these statistics, it is now projected that 10 to 20 percent of all partners of hemophilic men are HIV positive. With this in mind then it is logical to project that seroconversions to ARC or AIDS will occur in California with some frequency in the future and that perinatal transmission cases of ARC or AIDS are probable. Both actual figures or projected population data support 2300 individuals with hemophilia in California. This represents more than 10 percent of the estimated United States hemophilic population. In addition national statistics concerning AIDS and its impact upon spouses, family and significant others utilize a one-to-three ratio. It is thus estimated that there are 6900 significant others for an approximate total of 9200 persons in the hemophilia community to be served. The Council works very closely with the four local hemophilia chapters, the regional hemophilia treatment centers and blood centers in California to increase their coordination and sharing of information and resources concerning hemophilia and AIDS and AIDS-related activities. The Council staff has collaborated with colleagues from these other organizations to cosponsor workshops, health fairs, conferences, summer camps for adolescent and teenage hemophiliacs and other educational events that have benefited the entire hemophilia community.

These activities have established the credibility and track record of the hemophilia council, clearly demonstrating its capabilities and qualification as a strong, recognized statewide organization in the area of AIDS.

Most of the program activity and service to the hemophilia community comes both from direct outreach and referrals to the council from the regional hemophilia treatment centers and foundations or associations. Also, referring clients to the council are private medical and psychosocial providers, local health departments, military organizations, HMO's such as Kaiser, and other AIDS agencies.

In the development stages and in concert with the hemophilia treatment centers is a peer support program which is intended to provide peer group interaction at the local level. The council, also, serves other needs within the hemophilia community. Information and referral services include but are not limited to having responded to client interest in finding financial assistance and qualifying for state and federally-funded benefits, such as California's genetically handicapped persons program, California children services program, MEDICAL, SSI and others, information regarding new blood product development, information on alternative therapies to HIV infection, information on recalls of potentially contaminated blood products, information and assistance in resolving legal issues, such as problematic insurance matters, educational discrimination, employment discrimination and basic legal rights, information on the use of protocols for AZT and providing current information on AIDS-related legislation which may directly or indirectly impact the hemophilia community.

Statewide official statistics indicate that there were 85 hemophilic individuals reported as AIDS cases in California for the year 1987. Anecdotally through personal knowledge gleaned by our staff and persons affiliated with the Council, it is estimated that a more realistic number would be 250 who are currently having AIDS crises.

Present formulas utilized for estimating the number of ARC cases is that 5 to 10 people exist for every diagnosed cases of AIDS. Upon an ARC or AIDS diagnosis, individuals with hemophilia have the same health care and physical needs that manifest themselves for the gay and bisexual population. There are, however, some very distinctive and significant differences that need to be drawn at this time. An individual with hemophilia generally has struggled lifelong to fight physical limitations, isolation and discrimination in an effort to be just another member of society at large.

With the advent of antihemophilic factor concentrates and advancement in the care and treatments of the hemophilic patient during the last two decades, life expectancy has been extended from early adulthood to a more normal longevity paralleling society at large, and individuals with hemophilia have taken their rightful place in all segments of this society.

With fewer numbers, approximately one hemophiliac to every 10,000 male births as opposed to approximately 10 percent of the overall male population for gay and bisexual men and because of the attitude of denial common to chronic illness, there is not a basic sense of community for hemophiliacs, and they are widely dispersed throughout California.

What exists instead are the foundations and associations on the local level who are primarily voluntary consumer oriented health charities. Also, in existence are the hemophilia treatment centers. It is these treatment centers that are the hub of medical care for most individuals with hemophilia in California. Without impugning the character of any one center or particular physician serving the hemophilia community, from a physician's point of view, the control of the blood clotting disorder is the primary concern which receives medical attention without fully meeting all of the physical and psychosocial needs of the hemophilic individual. Hemophiliacs then who out of severity of their disease or economic necessity rely upon this medical care system in an ongoing systematic way without looking elsewhere to meet their needs beyond basic hemophilia medical care may not have the very early ARC or AIDS symptoms detected. Additionally there are an estimated few to several hundred individuals with hemophilia who due to a host of factors manage their health care needs with home infusion therapy and do not interface with either the local foundations or associations or any hemophilia treatment centers.

What, unfortunately brings the geographically dispersed and fragmented hemophilia community together is HIV. For the most heavily-infected HIV community in the state of California, there is no formalized delivery system to provide the full continuum of essential and appropriate health care and supportive services at home and in their communities. This is the primary need.

While some supportive services do exist, they are primarily, if not exclusively in some instances by self-selection and method of delivery tailored to the needs of the gay and bisexual community.

Self-selection by individuals with hemophilia is an issue that should be noted. One must recognize as it does exist, that a significant number of the hemophilia community have strong negative feelings about seeking out supportive services that are based in primarily gay and bisexual organizations. The very substance, the anti-hemophilic factor concentrate which has given hemophiliacs new life now threatens to take it away due to contamination by the AIDS virus. Homophobic, erroneous and misperceived or not, the perception exists with some hemophilic individuals that the gay and bisexual population bears the responsibility for their plight. Perhaps just as significant an issue contributing to this resistance to primarily gay service providers is that there has long existed an association between hemophilia and homosexuality. However, the common bond of this AIDS threat has in many instances led to a new alliance and sense of understanding between many gay and hemophilia organizations, as well as individual personal bonds.

It is in this juxtaposition of differing emotional bases that ARC and AIDS brings all individuals who confront it to one central issue, how to and who should meet the basic health care and supportive service needs caused by ARC and AIDS. The dilemma then becomes the same for all. The URSA Institute report on Page 27 summarizes the problem very clearly by saying, "Patients with AIDS and patients with ARC spend considerable amounts of time identifying and locating support services, qualifying for benefits and receiving the types of support needed to maintain health, functionality and independence."

What this doesn't describe is the time, the frustration felt in working with multiple bureaucracies, the many avenues to pursue and the diligence and effort required to be successful in doing so.

It is patently evident that fragmentation of needed services occurs even where some services do exist, and some eligibility for differing levels of service is available. It is then this lack of coordinated care which is, also, a primary need for the hemophilia community member who has ARC OR AIDS. Some basic support services are absent in areas where individuals with hemophilia, with ARC or AIDS require them. The burden unnecessarily falls to family and friends to sustain. As the epidemic of AIDS has grown and has widened its impact on society and on special populations in particular, it becomes the primary responsibility of those impacted communities to evolve and develop appropriate responses to that greater impact.

The hemophilia community is a special population that has gone through an evolution of being considered a "high-risk group" for AIDS to the most heavily infected population of HIV. The evolution of AIDS is continuing as evidenced by the increasing number of ARC and AIDS cases. This occurrence was recently acknowledged by Dr. Janine Jason of the Centers for Disease Control when she stated that the hemophilia population is now entering a peak phase of progression into ARC and AIDS among those who are HIV seropositive. With 70 percent of the entire hemophilia population being HIV positive and with 10 to

20 percent of the spouses and/or sexual partners of hemophilic men, also, being HIV positive, those numbers of new ARC and AIDS cases may be substantial. The need is to provide those necessary health care and support services at the appropriate levels but, also, in a manner that maintains individuals with ARC and AIDS with sensitivity and in comfort.

To overcome those gaps and barriers in essential services, coordinated care through case management is warranted and should be community based.

To meet the AIDS crisis and deal with it in the most effective and sensitive manner possible will require creativity and participation in a combination of federal, state, local governments and the private business communities.

The cost of care, we already know, will be staggering. We are a democratic nation rich in natural resources with an abundant belief in caring for those who are less fortunate. Why then should this AIDS health catastrophe be any different?

CHAIRMAN WATKINS: Thank you, Ms. Stephens. Dr. Saucedo?

DR. SAUCEDO: Good morning. On behalf of the Latino community, I would like to welcome you to San Francisco and to our community in particular. I welcome the opportunity to speak before you. I, also, as Dr. Ja, feel the burden of being the Latino to speak on behalf of a heterogeneous community. So, it is important to note that we are a heterogeneous community and to note that I am one person here and that on the panel, on the esteemed panel there are no Latinos, to my knowledge, and that that is pretty much reflective of our relationship with health care systems and that that is part of the problem that we face, not only in giving AIDS care, in education and prevention but generally in health care. So, it needs to be put within that context.

I would like to offer you an ancient Spanish greeting, as well "may the sun shine brilliantly on all of us." (Phrase delivered in Spanish.) This is a greeting that reflects how we relate to each other contextually, culturally which then leads me to the more prepared remarks which are reflective of that culture.

In late 1985, one-half dozen Latino activists from this community, gay and straight men and women activists, professionals came together to discuss concerns about the impact of AIDS. That had to occur because as far as we were concerned, the money and the resources of people to educate our community had not happened, although there were agencies that had the mandate to educate around these issues. So, as a community, we came together, not only to share the frustration about the lack of AIDS programs that were not linguistically nor culturally relevant but, also, to begin plans to share our awareness, understanding and to do a community needs assessment.

As an outgrowth of this, the Latino Coalition on AIDS/SIDA was formed. The coalition now exists, community-based community agencies, Latino agencies, gay and straight individuals interested in promoting AIDS awareness and education within the community.

In June 1986, the Instituto Familiar de la Raza on behalf of the community responded to a state request for AIDS education projects targeted at this community. We responded to the state because at that time we believed that the city was not responding to our needs and that for us this was an emergency, so that we had to proceed and seek funds wherever the funds were available, and if we offended, well, we were sorry, we had to offend, but it meant the lives of people in our community.

In July 1986, the state approved a grant of $131,000 for AIDS education and information to the Latino community at large. The project at that time was the only project of its kind in the nation. So, it became in a way a prototype, again, a burden for the small community but an honor. The goal of the project was to educate the whole community and then to target the at-risk populations within the community. The project is now composed of only three educators and a director, some volunteers. Throughout the rest of the system we have a small scattering of maybe four or five at the most bilingual, bicultural individuals who educate or give service. This is in all of San Francisco County.

As part of the process, we decided to use video for TV as a way of educating the population, and a video was developed called OJOS QUE NO VEN, and I might remark here because again it reflects issues of policy and of who determines what is normative in a community and who knows how to best organize an educate a community. OJOS QUE NO VEN is a video that is set in the context of what we call a telenovela serial, and is set in the context of a community, in the context of family life, in the context of all the characters that reside in the community, with all the variety of reality problems, of positive energies in a community. We deal with issues of substance abuse, sexuality, of prostitution, of single parents, of coming out for gay people, all of those issues.

The State Department of Health refused to fund it after we finished the product. So, this small community, this small agency had to find ways to absorb that cost. We did it, but again it reflects the basic issues of who determines these things for our communities, not only for Latino communities but for minority communities. The health educators use a number of activities from education forums, home meetings, street work, educating others. We are limited in the resources. This year we switched from the state department to the department of health. I think the efforts of this community, as well as other communities helped the department understand that the department had a responsibility, and so, we were funded for $162,000, but at this point the focus had to change because we had to fit into targeted areas which were the IV drug users and the high-risk population, gay and bisexual males. So, we have found ourselves now in a situation in which we are only able to target a part of our population and are unable to use the resources within our own population, such as our mothers, our elders who have been traditionally educators, and whom other people will listen to. Because of the limitation of the resources, we are not able then to train and utilize other resources that could contribute to the education of the whole community, and so, that is one of the issues that we fail in because of the limitation of the resources itself.

All materials, all treatment modalities must reflect not only the language realities of this community but the cultural realities. As I said at the beginning, we are a heterogeneous community. That means that on a cultural spectrum we are varied; we are like a garden, and say, in a garden you have orchids and roses and pansies, you have to give them special feeding, special foods, a certain amount of water to each one. It is different, and so the same thing with our community; we need different kinds of strategies for different parts of the community, and this must be taken into account any time that we develop either a treatment modality or an educational and information strategy.

I will give you a good example. Last year a translation was made of a poster that had a needle, and the needle, in English it said, "Don't share needles." You know, that is cool, as they say; that is all right. It was translated exactly with the needle picture only and with the words (Spanish phrase) which means the same thing, don't share. People in our community came up to us and said, "Are people pushing for the use of needles?" Because it was devoid of any context. It was just a needle in and of itself, and so that we cannot translate; we cannot translate concepts. We cannot translate language. The development has to be from the cultural concept and from the linguistic concept. So, it must be done by people who have that ability, that is bilingual and bicultural people.

I would like to move into some of the recommendations. I will try to stay within the limited 5 minutes, and some of the recommendations have to do with really issues of policy and criteria for programming, but we would like to recommend that any CBO, any city program that is funded to provide services to a population must then reflect in its board of directors, in its staffing pattern, in its design, it must reflect the realities of the population it is serving bilingually and biculturally, and in addition to that, there then must be criteria to assess that, and I think one of the things that happens in health care planning is that when you review a plan, say it is the AIDS plan, and they will have Recommendation 1, we are going to have appropriate relevant programs for ethnic populations, and then there is no way to operationalize that. All right, there is no criteria to assess that. There is no manner or way to monitor that, so that in all programming, whether it is at the federal, the state or the city, that must be part of the process that you can monitor and that you can assess and that the individuals who are doing that are individuals that we know what it should encompass.

If we look at recommendation No. 3 and 4, again, they have to do with prevention, with educational strategies, with strategies that are in the context of our community. We are very concerned about our adolescents. You know, adolescents not just in our community but in all communities, it is a time of experimentation; you experiment with drugs; you experiment with sexual activity. So, therefore, you are at risk. In San Francisco at present, it is very difficult to get appropriate materials for our different communities into the schools. They are refusing to use in some cases materials developed by the communities, and again, because they are using some other kind of criteria, and in many cases, it is just as simple as the materials, only in English, and if we look at the population of San Francisco schools, I think something like 70 percent belong to other cultures and speak other languages. So, we are missing a great opportunity in terms of prevention, and I think this is, again, something that needs to be looked at very carefully.

Let me briefly move into the area of treatment, and here I am talking about when an individual has been diagnosed or is considering taking the testing, that in these places and in these institutions we must have individuals who are going to be able to deal with not only with the medical issues involved but have to understand the spiritual needs of those individuals because as a population we still focus on what we call the non-material. It is important to us, and so we don't necessarily just want to be sent to someone else. We expect that the person who is there claiming to be a counselor is going to be able to deal with issues of economics, of social support, of emotional support, of cultural ties and of spiritual need. That is how we view a counselor, a helper of any kind, and let me just quote to you a couple of things that we have discovered in another project that we had that has been doing an assessment of need, and this is from Dr. Vargas' report, and these are some of the things that have happened to Latinos: A patient dying over a course of six weeks with no Spanish-speaking professional or volunteers on the staff, so that at the time of most crises of greatest critical need in the hospital setting there is no one that he can communicate with, unless someone from the community comes in, but we are talking here about the responsibility and obligation of the health system to serve all people; a patient leaving the hospital against medical advisement due to the harsh manner in which the diagnosis was given and the general lack of explanation of what was being done to him, and I know of this case personally because our institution was called and asked to intervene to see if we now could locate the patient so that there are issues here of cultural sensitivity on the part of the health caregiver, and I think much of this comes from ignorance. These are not bad people who are giving service. They are in health care because they want to give care, and so, it brings us to the issue of training and educating non-Latinos because one of our people because one of our difficulties is that we have very few people who are bilingual, bicultural in the health care systems. So, it means that we need to have resources to be able to in a sense retrain or give additional training to good people who are in the systems who wish to help, who wish to avoid the situation of someone rushing out of the hospital because of the way the diagnosis was literally dropped on them, partly because of language inabilities and, also, because of the insensitivity.

Let me use one other example, and this is a very recent example to me. At the Instituto we had a colleague, a Latino doctor, Ph.D., a brilliant man who came to work with us in a project called "Mano a Mano" which is a project working in counseling and case management, and he came to work with us in August, a gay man who at that time was in denial and because of the work he began doing, he had to come to terms with the fact that he had AIDS.

He died yesterday. That is a very short time from time of diagnosis to death. It is a shorter time than happens in the larger community. We must ask why. Now, here is a man who is educated, who is sophisticated and somehow the information out there did not reach him, and I don't mean he didn't read it; it didn't reach him; it didn't connect with him in a way that he could say, "This belongs to me, too." I think this is one of the things that has happened, not only in Latino communities but in all minority communities, so that then again, it speaks to how programs are designed, how information is designed and the resources.

I think as Dr. Amanda Houston-Hamilton said, "We know how to do it, and we have the resources in people, but we, also, need the money resources to be able to organize and train our people." Thank you very much.

CHAIRMAN WATKINS: Thank you, Dr. Saucedo. Mr. Tingley?

MR. TINGLEY: Thank you, Mr. Chairman and other distinguished members of the Presidential Commission. It must be noted that most of the top ten causes of early sexual debut are related to alcohol and drug abuse, and that the Native American populations have the highest levels nationally for alcohol and other substance abuse. Not surprising, then, was the report from the National Center for Health Statistics that showed a Native American teen pregnancy rate of 20.8 percent nationally. Additionally, it was not surprising that the Centers for Disease Control's 1985 study of seven states with large Native American populations reported sexually transmitted disease rates that were 10 to 100 times higher than the national average.

One must understand that the nation's American indian and Alaska Native population is relatively small, and for this reason, prevention is critical.

Projecting from our high levels of substance abuse, STD's and teen pregnancies, if our populations do not receive a 100 percent level of AIDS prevention education, we will be looking at the final chapter in Native American history after the year 2000.

The Federal Indian Health Service who has the primary responsibility for health care for the nation's Native American population has repeatedly refused to deal with this issue. Indeed, as late as August 1987, the Indian Health Service stated that "AIDS is not an indian problem," at the Centers for Disease Control's conference on minorities and AIDS.

Yet we know that there are American Indians with AIDS. Unfortunately, the Centers for Disease Control only reports 53 current cases. It is surprising that they even have any data at all. There is presently no uniform format of reporting AIDS cases from counties to states or from states to the CDC anywhere in the Union regarding Native Americans. Even under such adverse conditions, however, the local American Indian and Alaska Native community has proved to be very resourceful. All of the local indian community-based organizations and AIDS activists have come together to combat the epidemic and to prevent the spread of AIDS within the community. We have trained local Native American community members as emotional support counselors and community prevention educators. We have begun to develop AIDS prevention and education materials that are culturally relevant and appropriate, and we are developing community-based support networks for persons with ARC and AIDS and their families and loved ones.

In keeping with our concerns we, therefore, have the following recommendations. In regards to prevention, education and information, prevention education must be culturally relevant and culturally appropriate. Dollars must be made available to indian community-based organizations and tribal governments for this purpose. Non-indigenous care systems must recognize the reliance of indians on traditional indian medicine practices, both spiritual and medical, in addition to Western medical practices.

The Indian Health Service substance abuse prevention and treatment programs must, also, include funding for drug abuse prevention and treatment.

In regard to direct services to persons with AIDS, funds must be made available for case management services, since the majority of the indian populations rely on tribal government, Bureau of Indian Affairs or community-based organization social service agencies as their primary social service agencies. Funds for emergency, transitional and permanent housing must be made available for persons with ARC and AIDS. Funds for home care services that are culturally sensitive must be made available. Funds for peer counseling and culturally appropriate psychotherapy must be made available.

In regard to research, funds need to be appropriated for studying the level of intravenous drug use among American Indians and Alaska Natives. There must be a study conducted to determine the seroprevalence among American Indians, and third, and most importantly, a discrete category for American Indian-Alaska Natives must be established in all reports from states and especially from counties to states on AIDS and ARC cases specifically and on sexually transmitted diseases generally. Thank you.

CHAIRMAN WATKINS: Thank you, Mr. Tingley. We will open our questions this morning with Dr. Lilly.

DR. LILLY: Thank you, Admiral Watkins. One of my main interests in participating in this Commission has always been the problem of education of the public about the ways to protect themselves against the epidemic. You have brought home to us, as has been brought home to us before, but very poignantly this morning the diversity of the communities to be educated. Each of you has in some sense stressed that. Dr. Ja told us, I think it was of 32 identifiable Asian populations. Dr. Saucedo emphasized cultural differences among the subset of Latinos in our population, etc. This is a really terrible problem from my own experience in my activities the GMHC in New York. I remember, for example, with respect to the black population, that we tried to reach out to the black population, and we were quite successful in reaching out to the population of gays who were black, but on the other hand, we were very much less successful in reaching out to the population of blacks who were gay, if that distinction is clear, and I think that all of you might somehow say the same thing. Given this incredible diversity, how do we cope with this?

Some of you have suggested, and I think the Commission is already sold on the idea that serious education can only be performed by people who speak the language of those that they are trying to educate and who have the trust of the people that they are trying to educate. That complicates the problem immensely. It certainly does for us with respect to making recommendations because it is easy enough to say what I just said, "What do you do now?" I would like to hear from you a little bit about that. What do we do now? How do we go on with this coping of diversity within the population that you are concerned with?

CHAIRMAN WATKINS: Let me just try to put a framework on that because I think the point Dr. Lilly makes is extremely important to us. As the Commission, we are going to be making recommendations, obviously, on education. We have had testimony before, not unlike yours, as he said, that is leading us to perhaps a procedure or a process by which the fundamental information you need is provided, but perhaps you do the conversion of that locally, community-based organizations and other linkages locally to put it into the proper context. Even within the Latino community we have heard recommendations on one particular group. We might approach it this way, another this way. It is very difficult, I think, at the federal level to get into curriculum, and so, I think we are talking about providing the fundamental information in adequate quantity the way you want it and allow you then to prepare the necessary information to flow out into the community that is culturally sound. So, could you put it in that context and answer Dr. Lilly and let us perhaps hear from all of you as to what you would recommend this Commission do in approaching the broader issue of education along the lines that I just perhaps suggested, if that sounds attractive?

MR. TINGLEY: If I may be the first to address that issue, the Native American community is probably the most diverse, having over 400 different ethnic groups. So, this has always been an issue for us. One of the things that we are doing presently as I stated it locally is that we developing our own culturally relevant materials that can be used across the board with most of our ethnic communities. I think that is No. 1, very important, going down to the local source instead of how things usually proceed from the federal level down, but I think the most important thing about when these resource materials and such are being developed, we must not censor them from the federal and state level as they presently are being censored.

DR. JA.: Certainly first of all, I appreciate the Commission's response to the issue of cultural diversity. We certainly have that in terms of the Asian community with all the different types of languages that we have. One problem related to that is the fact that many of the terms that we are using in terms of addressing the AIDS epidemic don't even exist in our communities. There are no words. There are no terms. There are no definitions of viruses or AIDS or HIV in many of our Asian communities, particularly in the Southeast Asian communities. How do you then begin to address the problem when you have to begin the whole new vocabulary? But I think we recognize that this is at issue, that this is a problem for us to deal with, and we have been trying to deal with it. We, also, know that there are like 30 discrete steps in terms of taking a brochure and trying to translate it into a culturally sensitive piece of material to be able to present to our community, and the problem, I think, is the federal bureaucracy. For example, as Mr. Tingley has indicated earlier, it was only until the middle of last year that CDC began even providing us with statistics of Asian Americans rather than just lumping us together under "other," which unfortunately, Asian Americans, I believe, the Native Americans are still being put under, and that is a major problem for us. Now even obtaining information on Asian Americans really does us little service. What we need is information regarding the rates of Chinese, Japanese, Korean, Filipino. We know in San Francisco which does provide these statistics there are differential rates of AIDS among these particular groups, with Japanese actually being the highest, but again, without the recognition by the federal institutes like CDC, NIH, we are not going to be able to do anything.

MS. STEPHENS: Actually it is a threefold problem. They are dealing with minority populations, and hemophilia is across the board a compilation of all of the minority groups and so, we have very difficult problems in accessing the community. The community is inherently withdrawn and closeted and because of the crippling effects of hemophilia in earlier days, individuals were singled out. They just simply were not part of the mainstream. Therefore you have three issues. One, I think that it is imperative that government determine what its official role is going to be in this crisis. In the absence of a national designated policy in terms of dealing with AIDS and the AIDS crisis, and treating it as though it is a significant problem in the same way that we dealt with polio and a myriad of other diseases, the distaste with this is that it is a principally sexually transmitted disease or that it is spread by doing activities that are not perceived as legal, and it is abhorrent to the general population. There is significant fear. We must have not only a national policy but each state must, also, follow the national description of the policy in terms of dealing with AIDS and how one is regarded in the community.

The second issue is the significant mental and psychosocial impact. It is very difficult to deliver an educational message, if you do not have one's attention. It is rather like dealing with a horse. If he is unable to follow instructions, you smack him between the eyes, and suddenly you have his attention. You cannot do that with printed materials. So, there has to be supervised peer support within each of the local levels. There is no other way of accessing communities who are at risk or even the general community, most of whom perceive themselves as not being affected by it.

The other is once having dealt with the mental health issues, the stigma of perhaps being at risk or that one has led a quote, loose life and therefore is now HIV positive, we need to have basic human services, and they must be delivered in a manner that is sensitive and acceptable. We do that for all other forms of illness, but we don't do it with sexually transmitted diseases, and we don't do it with AIDS, and I am not blaming government. I think that it is not just government; it is even within our own community there is sufficient denial that I don't do those kinds of things, therefore, I am not at risk. So, it has nothing to do with whether it is palatable. It has to do with a health issue that spills over into all segments of life styles, but you have to have peer support. That is first and foremost and supervised, and you must have a mental health component.

DR. LILLY: How can we foster that?

MS. STEPHENS: I think that the most effective way of doing it is handling it by community-based organizations who are best in a position to speak the language of the population. I would not, for example, because I am not fluent in Spanish, presume to go into the Spanish community even though we have a significant number in the hemophilia population. My godmother is Spanish. It is an embarrassment to me to live in California and particularly come from San Diego and have a cursory knowledge of the Spanish language. So, I think that the messages must be delivered in an understandable, articulate manner for not only the level of understanding but, also, the cultural understanding.

DR. LILLY: Do you know the best way to do the education is funneling support to small groups who are in close contact with the communities that they deal with?

MS. STEPHENS: For example, our peer support program is not salaried, but in the grant that we wrote we provided a stipend so that they are not having to suffer out-of-pocket expenses. It allows them the freedom to make telephone calls, to travel throughout the region, and since we have only four offices, we are multiregional or multicounty in each of the subregions. So, I think, yes, that would be an appropriate way to go, but you cannot send unskilled people into the community without direct supervision.

DR. LILLY: So, we have to train the trainers.

MS. STEPHENS: Precisely, and that is a very effective program, I might add. The Nurses Association is doing it. Red Cross is doing it. It is very effective.

DR. LILLY: Others of you might want to address the subquestion here. If we go that route, which I am already sold on that, but assuming that we do that, how do we monitor 10,000 or more groups in this country, each receiving, presumably an unfortunately small amount of support to do this type of work? The government is not very happy about giving up money without some kind of demonstration that it is doing some good. How do we determine that?

MS. STEPHENS: An effective way, I think, if I might be presumptuous, an effective way of dealing with that, I think, the local health departments, county health departments and the state health departments are the natural extension of the Federal Government's health agency.

It would seem to me that there could be in place a division that monitors those kinds of activities, without superimposing their attitudes. Now, that is the key. It is not for them to come in and say, "You will do this or you will not do that. I think that they need to supervise as it pertains to how -- it is a straight bookkeeping issue. How does the message on this side of the page translate into the dollars that have been allocated to perform that particular activity?

DR. LILLY: Dr. Saucedo, do you know how to determine that? How do you measure the dollar value of education?

DR. SAUCEDO: Let me go back to the previous question because I would not agree that the state health department would be the most appropriate vehicle, I think because all of us have found that they don't have in place that kind of understanding. Some of our difficulties that we all have had have been with state and local health departments.

I think for us it might be another kind of vehicle. We all participate in coalitions that reflect not only cultural realities but are composed of people in the health field who are a part of this community who in a sense then wed, you know, both cultures, and that locally perhaps, and we have to give a lot of thought to these kinds of things, and I cannot do it off the top of my head, but that perhaps these kinds of local groupings would be able to develop those kinds of criteria by which you assess whether a local group has the capacity to really educate this particular community or how effectively it is being done. We all have professional groups in our communities. So, I would think we might want to maybe take some time to reflect on that and think of that kind of possibility, because certainly for Latinos we do not have individuals in the health care system who understand these things that we are talking about. That is part of the problem. So, we are going to ask in a way the systems that have created some of the institutional barriers now to assess whether the job is being done appropriately. You know, that to me is a contradiction in itself.

DR. JA.: Let me just make one remark regarding that issue of how do you begin to serve those communities because we have a model in the Asian AIDS project with our funding base. We actually subcontract $80,000 worth of funds to smaller organizations in each of those Asian ethnic communities. For example, we provide $20,000 to the Japanese youth center who then provides AIDS education to that particular community.

Now, we are the primary contractors with the San Francisco Department of Public Health. What we are doing is trying to train a base in each of those ethnic communities by first providing them with small sums of money, educating their staff and, also, getting that community to understand that it is not my problem or the city's problem but that community's problem as well. So, what we are trying to do is train bases. We have subcontracts with the Vietnamese community, with the Filipino community, the Korean community and with the Chinese and Japanese communities. This is one model in which we are doing and trying to build a solid base so that everyone eventually can actually individually apply directly. We do have a track record in my organization. Many of these other organizations do not. Hopefully we can raise their expertise to a point where they can, also, begin to apply directly.

DR. HOUSTON-HAMILTON: I think this is a really crucial point, and I think one of the things that is making Dr. Ja successful in what he does is that it is an Asian program that is monitoring and overseeing that process. I think one of the things that is going to have to happen is we must acknowledge that some of the messages that are being put out about prevention have to acknowledge that they are culturally based and, in a sense, are getting in the way of some of the more effective messages that we need to present. We find ourselves having to undo some of the messages that are being presented by AIDS educators in the city. I mean the whole issue of promiscuity, for instance, is not a primary issue for black women. Heterosexual black women are among the least promiscuous group of people, have the least numbers of partners of women in studies across the country. The AIDS prevention issue for black women is not promiscuity; it is condom use; and yet what we do is we feed into their denial, because they are able to say, "I only have one boy friend," or "I am married," when this is the group that is becoming infected, and you look at women who have become infected, they, themselves are monogamous. So, we find ourselves having to undo those kinds of messages. Furthermore, in San Francisco where we are continually hearing that, in fact, AIDS is a white gay disease and will continue to be a white gay disease into the 1990's, then we are being expected to come back and deal with the, "denial" in our communities. One of the things that we are going to have to do is to acknowledge the cultural and political bases of some of the AIDS messages being put out and to have those issues side-stepped.

Second, we must begin to disinvest in the model of AIDS education we have. I think that there has been a great deal of careerism and a great deal of investment in the creation of specific materials and a model that now is being promoted. It troubles me that the model is now being transmitted, sometimes swallowed whole hog by ethnic communities, rather than starting from what they know and what they do in our cultures. Brochures are a tool. They are not an end. What helps people in our black community change is when somebody whom they care about cares about an issue. That is what makes them change, not reading a brochure, not even looking at a video. That may begin to spark their attention, but that is not an end in itself. The other issue is the issue of evaluation. Each community has a care network, which is our best hope for stemming AIDS.

One of the things that I found when I was in Boston was a whole network of informal care providers. I called them "community consultants" because they were providing indirect service delivery in that community, and they knew how to get service that those of us in the institution didn't. There are networks in the community that are formal and informal, and are inherent and unique to each community. Each is like a fingerprint that exists and that needs to be acknowledged, needs to be supported with technical assistance. Some of that technical assistance is already available within the community, and I think Dr. Ja's model is an example of that, but, also, evaluation does need to be built in, so that we are building skills for people, and we are helping them to buy into this issue, to understand that AIDS is an issue for them. We need to leave these communities with more skills and better off than when we started, including skills to do evaluation, and an understanding of the importance of feeding evaluation information back into what they do.

CHAIRMAN WATKINS: Mrs. Gebbie?

DR. HOUSTON-HAMILTON: There is one last issue though that I think is important. It is that we, also, have to get away from the insistence that professional degrees have something to do with the level of expertise. We find ourselves unable to provide service in our community, for instance, with gay-identified black men because men who want to do this work don't have a bachelor's degree although have been out on the street, know how to reach people, and could, this day, go out and bring PWAs into these agencies who are alone and who are hungry. But we cannot hire them because they don't have the degree. We have got to get away from that limitation if we are going to be effective.

DR. LILLY: I will pursue that just a second longer. How would you go about convincing somebody that these people are capable of doing what you know needs to be done?

DR. HOUSTON-HAMILTON: I know two men, for instance, who have written their resumes with equivalent experience, who can document the work that they have done that has put them in a position to meet a job description. I think there are any number of ways to do it. Harvard University accepts people without degrees on the basis of experience. They seem to have a way of evaluating it.

MRS. GEBBIE: What is the source of that restriction? I am not aware of any restriction in any AIDS money coming to my state from the Federal Government that puts a restriction on the kinds of degrees that we can hire in people nor am I -- I am from another state, obviously -- nor of any restriction that automatically comes that does that. Somewhere you have gotten that visited on you, and it may have come through some monies that go to universities, and then the universities make decisions that people have to have certain degrees.

DR. HOUSTON-HAMILTON: It may come through the departments of public health. It may come through other institutions, but there needs to be some statement about the level of expertise that we need. In our community degrees are not what is respected. It doesn't matter to people what degree you have.

MRS. GEBBIE: Would you do me the favor at some point of tracking that particular restriction or at least sending us the documents on which it is based. I would be very curious to try to understand the origin of it so that if we find a way to recommend its removal, we know where to point the correction to the problem.

DR. HOUSTON-HAMILTON: I can give you examples of job descriptions that have come across my desk.

MRS. GEBBIE: Yes, I would like some help trying to track it back to where the limitations were imposed on it so that we can figure it out. So, if you would be helpful in getting us some things on that, I would very much appreciate it.

DR. SAUCEDO: I would like to add and kind of underscore what the doctor has said because I think that there are similar issues in our community, and it appears that when you apply for money there is a kind of -- it is not always stated, but when you are putting together who is going to do your service, they ask in terms of what degrees do these folks have, and when you try to put it in terms of what experience they have in the community, then you run the risk that you don't get funded or that you have to play with it. So, it is these kind of informal networks functioning at departmental levels, and certainly in our community the person who can educate the best is the lady down the street who knows the other lady who knows her business, who talks with her every day and who is skillful with language and whom they listen to. You know, we sometimes call them gatekeepers, right, an elder person whom everyone knows and that everyone talks to and that everyone goes to seek advice, and it is these kinds of people. They do it all the time on many other issues, as well.

MS. STEPHENS: I can address that.

MRS. GEBBIE: Again, I don't want to dwell on that one because there are other issues we need to get to.

MS. STEPHENS: I can answer where this arbitrary standard in terms of one's qualifying for a position. As a member of the California AIDS Advisory Committee and a member of the Department of Mental Health AIDS Task Force, the funding for most of these community-based organizations in California is generated through primarily those two departments in a very small way, the Department of Mental Health, in a significant way, not significant enough, but a significant way through the Department of Health Services Office of AIDS. The job description is tied to the standard set by the state personnel office, and it is tied to the salary level so that if you for example, wanting to hire someone, and the job description says that that individual will perform duties as if he were a health educator 1, and there is a salary that is attached to that, that determines what the qualifications are, and since we are contracting agencies with a state department that has a fiduciary responsibility to the taxpayers, they have required that we determine our job description. We say that it is going to be a health educator 1 position or whatever, and we tell them what the salary range will be and what is required in contracting is that that salary range be tied to the state personnel office and the salary range that the state personnel office provides for that designated position. So, it is not just the designation of the position. We can write our own job descriptions, and the state does not intervene in that, but if we put a salary, a dollar amount on it, then we are locked into whatever that salary range position is.

MRS. GEBBIE: Thank you for that clarification. I would like to shift to another aspect. Several of you referred to it in your presentations, and that is this issue of censorship of materials, and that is a word that several of you used, and I am certainly very much aware of the process that is put in place to make certain somebody isn't offended by the use of community panels to approve materials.

My understanding of the idea is to make certain that since it would be all right to set a federal standard for materials, at least at some state or local level somebody reviews it. Comments really from any of you or all of you on whether minority groups are represented on those panels or whether you think we need some special panels composed specifically of the communities which you represent to review materials being used in your community; are the panels in general being overly cautious? Are you sensing some of that? Is the censorship being put on your materials as you have identified it being put at approximately the same level of censorship on sexual explicitness that other communities are, also, very frustrated about or are things being censored because of some cultural thing that is other and different, and specifically Dr. Saucedo, you mentioned a film you had made that sounds quite wonderful that was apparently then not funded, and could you clarify for us what happened there?

DR. SAUCEDO: Yes, I would be happy to. The censorship was at the Department level to my knowledge. It was not reviewed by any community panel at that level. Our own community was involved from the beginning in selecting the process, the treatment, the material, everything so that we were reviewing it continually. I mean this is just people, right, the mother, young people, older people. They were a part of the process, and so to us it was rather peculiar that what we were told was that if we, after the product was finished, if we reimburse you for the product, then it will not get disseminated in California or anyplace else. It will sit on the shelf. So, then we had to make a determination. We had this video that had impact. It was a useful tool, and that the community, not just the San Francisco community but farm workers, individuals in our communities that are considered to be the more conservative in terms of how they express themselves reviewed it; they liked it, older people. So, it was clear to us that it was functioning at a level of people seeing things in which we had not made judgments, so that we have scenes in which an individual leaves the bar; you know, he is drunk; his wife is pregnant; he gets involved with a prostitute. There is no judgment made about that because that is reality, you know, and that is connected to issues of the prostitute or the user. So, the issue was now this individual is at risk.

That is what we were trying to point out because of these behaviors, and we know that if we begin making judgments people are not going to listen. So, there was a scene, also, of a young individual who was a user, and his counselor came by, and explained to him how you could clean the needles, so that the message that we got was that you are laying out these things, and you are not making kind of like a moral judgment saying that you are not supposed to use drugs; you are not supposed to have premarital sex or extramarital sex and that it was on that basis that they determined that they would not fund it, and yet our community, because you would have to see it, it is in a context; it is contextual, and it was culturally contextual so that people who are very catholic in some cases and very moral could say, "Hey, they are not saying that you do or don't. They are saying that this is the reality," and therefore we must change some of our behaviors. We must begin doing something differently. There is a scene in the video in which the mother finally talks to her daughter about sexual issues which she had never done before which is a difficult area oftentimes, but because of what was happening she began doing that so that the lesson; there is another kind of lesson of mothers and daughters and children need to begin to talk about these matters in a way that is appropriate, so that for us because we, as a community said that we are not making judgments, that was the norm, and here was another community of people which reflects a particular cultural view. Perhaps it is the bureaucratic cultural view of safety, right, of not rocking the boat in California. Let us speak plainly. Right in California, it is at present a certain more conservative political view that has certain moral underpinnings to it, that not everybody necessarily agrees with. So, I mean those, I think were all the elements that went into it, and we made the choice then of taking on that burden because we wanted to see this disseminated because there was nothing in the whole country, and actually this video as a tool now has gone I think to 25 states, to 12 different countries, you know, many places, and to me that is censorship because our community has norms, and our community reviewed it, and our community said, "Go ahead."

MRS. GEBBIE: And you haven't been able to identify a community panel or any other group outside of a bureaucracy --

DR. SAUCEDO: Right.

MRS. GEBBIE: Actually we are using your film in Oregon.

DR. SAUCEDO: Thank you.

MR. TINGLEY: I, among a couple of other people in the room sit on the State Indian Advisory Council on AIDS, and we are trying to develop some culturally appropriate posters and pamphlets and such, and the funding for this comes from the state Office of AIDS, and monthly and sometimes weekly the state Office of AIDS puts out words that are censored. You cannot use these specific words. You cannot use any slang. I know this is probably a problem for other communities, but we have what might be termed words that are pan-Indian English, if you will, and those cannot be used. So, it has been very difficult for us to try to develop materials that are culturally relevant when you have a state agency that is consistently censoring what you can and cannot say.

MRS. GEBBIE: Let me be clear? They are mailing you lists of words you cannot use in advance of your designing materials and submitting them for review?

MR. TINGLEY: Yes, they put out --

CHAIRMAN WATKINS: Mr. Tingley, do you know what the origin of that proscription is? Is it legislation that is passed by the state legislature that defines certain things or Supreme Court, California Supreme Court rulings?

MR. TINGLEY: I believe it is out of the administrative office, the Governor's Office.

MRS. GEBBIE: I think Dr. Houston-Hamilton had a comment on that.

DR. HOUSTON-HAMILTON: I just had an example of some of the consequences of this one. Through Polaris, we conducted the survey of knowledge, attitudes and behaviors in the black community, quite a few women who had had several children said that they had never had "vaginal intercourse." Yet, that is the standard term that we must use. Granted, it is very difficult to come up with synonyms for vaginal intercourse that don't offend someone, and what we found best is to use descriptive terms, but what that basically means is we may pour a great deal of money into AIDS education and get very little to show for it, because people don't understand our words.

MRS. GEBBIE: And that is what we are very worried about.

CHAIRMAN WATKINS: Dr. Lee?

DR. LEE: There are two areas that I wanted to address. First of all, Ms. Stephens, what did you really mean by there has long existed a societal association between hemophilia and homosexuality? I didn't pick up on that.

MS. STEPHENS: It is the first four letters of hemophilia and homo. Frequently youngsters are teased at school. It starts at a very young age, you know, saying, "Oh, I know what you are. You are a homosexual," that kind of thing.

DR. LEE: I see, okay. Now, the second thing is that with AIDS, our panels that come before us, continually bring up these gut issues in the United States. This panel has presented better than any other that has come before us the strengths and the weaknesses of the multiplicity of ethnic groups in our country. The strength of America is that it has multiple ethnic groups, and it has been said that the weakness of America is that it can be divided from within because of these multiple ethnic groups. I tend to be a lumper. Other people tend to be splitters. We totally understand the need for individualization of the educational effort, but is there no way to get together on this?

The Gay Men's Health Crisis, for instance is not the "gay men's white health crisis." It is the Gay Men's Health Crisis. I mean cannot we get everybody together on this?

DR. SAUCEDO: I guess I am a believer in gardening and in the beauty of the diversity, you see, and I don't think to recognize diversity does not mean that it separates us. That is part of the difficulty that sometimes people are afraid to say that. They are afraid to say that I have got this program which is based on the white model because it has certain assumptions, right, that we have a different cultural perception, different values. This doesn't mean that we cannot live side by side and work together. We have to recognize that. So, someone says, "Okay, I have this model," but the person would have to say, "But it may not work with this population," and people are not saying that. They start from the assumption that this is the model. So, let us use it here, here, here, here and here.

DR. LEE: I am not talking about the fact that the model cannot be different, but so many of the different organizations have resources that it seems one organization could use the other's.

DR. SAUCEDO: I agree with that, too, but I think then one has to look at that some people, individuals have not gotten beyond their own racism, and these are words that may offend and people don't like to hear it, but that is the reality or their own kind of cultural chauvinism, and that is what we are dealing with. That has to happen. We are ready for it, and we work together, and we try to work together with other groups, but there has to be a mutual respect and an acknowledgement that we do know what we are doing. You see, it cannot be, "Oh, yes, by the way, we put together this poster. Now, by the way, will you come and review the poster?" It doesn't work that way. It works if you say, "Hey, we have got this money, and we would like to hire on some people to work with us on developing this poster, because we have other resources, and let us do it together," and then it does work.

DR. HOUSTON-HAMILTON: I have been invited to several conferences lately where this issue of partnerships keeps coming up. I find myself getting very emotional about the issue, and it took me a long time to figure out why I was getting so emotional about it. One of the problems, at this point, in the notion that there can be a central agency that will then coordinate this whole effort is, for many of us, there is so much water over the bridge or under the dam, wherever the water goes.

[Laughter.]

DR. LEE: It is not over the bridge, we hope.

DR. HOUSTON-HAMILTON: It has taken the bridge away at this point. I think it is going to be very difficult. The process itself of undoing the hard feelings that have come along the way, of the years and years of wanting inclusion in this issue and being pushed away, will make it very difficult now to turn back around and develop the kinds of partnerships that I hear talked about. One of the things that those of us from our communities begin to ask is why now; after all this time, why now do you want to get involved in this, and so I think that the notion of having a central place that is going to be doing everything, especially if they have <u>been</u> the central place working on AIDS up to now is going to be difficult. That is not at all to take away the work that has been done in those places. It is simply to say that at this point we have too many other historical issues.

Secondly, as Tim Wolfred said to me, said to several of us in this city, if a black agency had come to the gay community and said, "Let us talk to you about AIDS," it wouldn't have been effective there either. People from our community have to see that it is organizations and people from our community that are behind this, that are spearheading this, that are in control of this, not being puppets and subcontracts on this issue. Information goes through a community; people know where AIDS education or service is coming from. We are talking about effectiveness and it is not going to happen by restriping the zebra. This effort really has to grow out of a community.

The other issue is, I don't see the utility in making those monies more diffuse by making them a step away or two steps away from the people that they are serving. So, it may seem as though a centralized focus that then disperses money or services is a more efficient way to do it. I think ultimately it is going to be more difficult because all it does is create a bureaucracy, and I have watched AIDS in California become a major bureaucracy, and I think that we have lost a tremendous amount of funds in supporting bureaucracies and overheads of organizations rather than getting it to --

DR. LEE: We don't want a bureaucracy. No, I was talking about just calling each other up more and sharing.

DR. HOUSTON-HAMILTON: Oh, we see each other all the time. We know each other around here.

DR. LEE: We are running out of time. Let me get on to my next question? The demographics here in California, as it has been presented to us, indicate that this is mainly, restricted to the gay community.

Now, Dr. Primm has brought up that maybe the statistics are not adequate and that you have a much bigger drug problem here than CDC is aware of, and I would tend to probably agree that Beny Primm is right. But one of the things that interested me when we were down in Miami and interests me here now is I have always thought of the family as being one of the major bulwarks against promiscuity, getting lost in life, alcohol and drug abuse, etc., and the communities that I identify with having the strongest families and religious backgrounds in America are the Spanish-speaking communities, and I would have thought, also, there would be tremendously close bonds within the Native American community, and yet these communities are right at the forefront of being racked by all these problems. Has something broken down here?

MR. TINGLEY: May I say that in the traditional sense what you say is true, but understand that the Native American population has been through the worst holocaust that mankind has ever seen. We have lost over 200 million people during that process, and what we have left now are very colonized people who continue to be colonized internally within this nation. I am sorry to say that the United States was the first country that has as a policy apartheid.

DR. LEE: May I say, from a totally personal point of view here , that I enormously sympathize with Mr. Tingley. For his people, all of the rest of us are immigrants, and so, I am with you all the way.

MR. TINGLEY: Except for my Spanish-speaking sister here who is, also, a Native American.

DR. LEE: But aren't your tribal and family relationships still very strong or has that really broken up?

MR. TINGLEY: It is still very strong. However, constantly we are faced with forced assimilation even though it may not be very public. In our tribal areas, nothing is in our language. Kids must go to school and learn English. When I was going to school, I was beaten for not speaking English. So, you see the system that we have to deal with is not conducive to maintaining our family systems, is not conducive to maintaining our cultures, and I think that is part of the process in what I reported in a conference in Geneva just this past week, that this process is one of the reasons that we do presently see a growing level of substance abuse and alcohol among our people.

DR. JA.: I would just, also, like to add that Asians, also, have a long history of having strong family bonds for thousands of years, and that part of the problem in our community is the fact that there is a large immigrant population, and given the fact that there is actually very little support to support traditional Asian cultural traditions and values, we have a tremendous amount of breakdown especially in communications between our families. We have families whose children grow up without being able to communicate to their own parents who speak a different language, and those are some of the problems that lead to a large number of Asian youth today who are substance abusers, and it includes IV drug use, particularly in the Tenderloin of San Francisco and Mission District of San Francisco. These are problems that we are running into. My organization runs a substance abuse treatment facility, a residential long-term facility, and we have a waiting list, and since we have opened our doors, we have had a waiting list, and these are Asian youth. Yes, we, also, abuse substances.

DR. SAUCEDO: The Latino community is indigenous to this continent, and we have been under siege. It is not that our families are disintegrating. Our families are struggling to change and develop ways of surviving and continuing and continuing the culture, but there is great stress for us and for our children. Economically we are at the bottom. Politically ditto. California, San Francisco, extremely high dropout rate. Stresses of being economic and political refugees, as well. So, it is difficult when all around you the society represents all the things that you should have and all the immediate gratification that you should have. You walk down the street, and you can buy crack. You can buy coke. You can buy dope. You can buy whatever you want to make pain disappear, so that we are talking about people responding to conditions around them and self-medicating in very dangerous ways, and then we have to talk about, say in San Francisco, we don't have a drug program to treat Latinos. We don't have a residential program for our kids when they may have to be removed from an environment, and so those are the things that then lead to that abuse to that medication. You know, if we relate all of that, as well to AIDS, how can in our community we talk about AIDS and treating AIDS if we are dealing with an IV drug user on the street who maybe wants to clean up, but there is no place where he can go in which the treatment will be suited and in which he will remain in treatment; what do we say to that individual? Clean your needles? We are not offering any hope. So, it is an issue, and it is an issue of struggle, you know, for survival, but I think all of our families in all these communities are still strong, the ties. They change. They are under siege, but we struggle to keep them.

DR. HOUSTON-HAMILTON: I know that the stereotype of the black family is everything but strong, but I beg to differ because I think that when you look at the experiences that black families have had to go through of literally being separated from each other, and sold away from each other, and moved about, that they have managed to maintain at all is a testimony to their strength. In fact, this is one of the issues in the cost of AIDS to us, because when we are working with a person with AIDS, we have to work with the whole family, because the whole family becomes involved. We do certainly have situations where there is a disaffected family, but even in the face of tremendous amounts of antisocial behavior on the part of a loved one there is very much reluctance to let go of that person. I think as many people have mentioned here, we have to look at the many factors that have gone into creating this crisis, and I think Representative Waxman put it best when he talked about AIDS as a metaphor for all of the weaknesses in our system. We have to look at the development of second-class health systems and the disaffection of black people with the health system that makes them postpone their health services for such a long time, and we have to look at the options and choices. When I see a young black man riding in a red BMW with a skyroof and a phone in his car, and I know where he is getting his money from, I say, "What on earth does this society have to offer him that is comparable to that? What are the options that we are providing for this kid? I think we have to look at those broad issues and not begin to blame the victim. I think that there certainly are a number of issues that have become complex and destructive in our community, but I think if we are really going to get to the business of solving them we have to look at the broader problem of AIDS.

CHAIRMAN WATKINS: Thank you very much. We are going to move on. We will have time for dialogue with one more Commissioner. We are running overtime, and we will have to move on to the next panel before long. I would like the remaining Commissioners, if they would, to frame their questions the way that the panelists can respond to us in writing. I will do the same thing, and so, we will ask Dr. Walsh to proceed next, and then we will just ask you the questions this morning in open session here. I think it is important for all to know that we are interested in certain things and ask if you would respond to us in writing on those questions. Dr. Walsh?

DR. WALSH: In the interests of time, I will then, Mr. Chairman, primarily make a comment which I hope will spark the response that the Admiral has suggested in writing, and that is that as a chief executive officer of a private organization, Project Hope which has worked extensively both with Native Americans and the Latino community, over the past some 20 years, really, I think that it is important for the Commission to know that you have told us factually what is going on in the real world of these populations. To even question the thought that when you apply for grants or whatever it is, that these grantees or grantors don't call for artificial degrees at the top and so on is simply spurious because the grants are granted by officials who are advised by intellectuals with Ph.D.'s and one thing or another on their advisory committees and we see that as a PVO just as you do, and the minute you divert from what they consider the norm, you are unqualified. We all know that. Anyone who has been in this business knows that, and I am glad that you emphasized it because it is hypocritical for us to think overwise.

The other aspect of it is that there are ways, and you have sought them in getting private funding and sometimes matching funding in which you can put in the kind of curriculums that you wish because you are paying for it with your private funding part rather than the federal or state funding, and what I would like you to help us with is we have extensive programs going on now, particularly in the Latino communities of Arizona, Texas, California, New Mexico in which we have been training health personnel on a broader base so that health personnel would get into those communities speaking the language of those communities. Not only on AIDS, but on all of the things related to health which we find this the best way to get a broad base of support from private agencies, and I think you have a great opportunity to use AIDS as a wedge for training of personnel that come and education that comes from these very communities. What I would like you to help me with is as we start to develop our training programs for AIDS counselors along with substance abuse counselors, I would welcome your ideas for inclusions in the curriculum any copies of things that you have, and I would welcome the opportunity to send some of my staff people who are involved in this out here to visit with you so as to help us in the drawing up of these curriculums which would be used in your communities, because as Frank Lilly mentioned earlier one of the things you know you have to do is, also, train the teachers to train the counselors, but they must be from your own community groups, and if you would do this for me, if it is not improper as a personal thing for Project Hope but, also, I think it would be of great benefit for the entire Commission because again you are right that you cannot criticize the federal and state governments entirely. They come out with federal guidelines or state guidelines, however unrealistic they may seem to you, but through the private sector is the best way to come back at them with modified curriculums and gain acceptability because the very people who elected them are the ones who are supporting you privately, and I think it is very important that we do that, and so, I would welcome all of your ideas, and I think that I would personally certainly share them with the Commission because we are in the process of training health care workers among these communities now. We have trained almost 2000 Latino health care workers just in the last three years who are now employed and working in Latino communities, but I don't think we have done the right thing so far in reaching the communities that you are talking about today, and that is why we want to improve what we are doing, and you are the people who can help us do that, and we can extend this to the other ethnic groups as well. So, I really appreciated very much what you all have been through in the people-to-people sense but in your own communities, and I thank you very much.

CHAIRMAN WATKINS: Dr. Primm?

DR. PRIMM: Mr. Tingley, you had indicated your trepidations about the year 2000 that your populations would be decimated if education and prevention efforts are not concentrated on reservations. I looked at the CDC report earlier and found that they have reported that 55 Alaskans or Native Americans were diagnosed to, of course, have full-blown AIDS nationally, and here in San Francisco only two have been thus far diagnosed, and I was quite shocked by that figure, and I think it is indicative of certainly underreporting, no intravenous drug users whatsoever and no homosexual, bisexual intravenous drug users. Among Asians, Dr. Ja, there were four intravenous drug users and two homosexuals and two intravenous drug users, and among Hispanics 18, 11 intravenous drug users and, of course, 7 homosexual, bisexual intravenous drug users. I was shocked when you told me that there are no treatment programs here for intravenous drug users in San Francisco that are relevant to Hispanics or relevant to Native Americans, and you, of course, are running a drug treatment program.

I would like some information on that because I find that to be quite shocking. I know of a couple of treatment programs here that even have outreach to the community and perhaps maybe their outreach efforts have not been such that whatever they are saying is not embraceable by those people who are in need of services, and I would like to know that. I would, also, like to know, Mr. Tingley how you would recommend to this Commission to go about doing seroprevalence studies among Native Americans because that is a most important issue. If there is underreporting in this nation about that population, then indeed, we ought to have some way of getting at their numbers, getting at their numbers that would be acceptable by the Native American, Alaskan American population. Many ethnic groups are quite opposed to seroprevalence studies among them because they feel that it singles them out, etc.

Now, I think we need to know that, and I think this Commission would like to act on that. One last thing in writing, I mean all of you have made serious complaints about the lack of support, the lack of education. I gleaned that from your testimony this morning. I wonder how much of San Francisco's dollars are going into the Native American community, going into the Asian community, going into the hemophiliac community, going into the Hispanic Latino and certainly the black community; in terms of the total number of dollars, what are those numbers, okay? That would give us some idea of the equity and parity of distribution of funds relative to both your populations and your representation in the problem itself at this time.

CHAIRMAN WATKINS: Do you like your homework assignment, panelists? There will be more. Dr. Crenshaw?

DR. CRENSHAW: Yes, I would like to ask a couple of questions that I would really appreciate responses in writing to. One is that in each of your groups, I would like to know what thoughts and provisions and plans are being made to anticipate the needs of children who were not infected through the birth canal but are the children of two parents who are infected and who will probably become orphans. They don't have the special medical needs of boarder babies and children who are HIV positive, and I think it is really important to think about them and to look at what existing resources can be used and what new resources need to be provided to help them in the transition when they lose their parents.

The second thing I would like to ask is about the Indian community. I have heard anecdotally things I cannot substantiate about the tremendous extent that is suspected of the HIV infection among the Indian community. As you said, and I was happy to hear this issue raised, the public health figures indicate that the problem is not significant yet. Can you advise us in writing what can be done to clarify the scope of infection so that we can document the problem better and then be in a better condition to respond to it?

In relation to all of your groups that you are representing and that you are trying to help, one of the things I think is critical is the sexually cultural differences. On the one hand you need to be able to communicate to them in explicit language, and sometimes that explicit language is just in Spanish because they don't understand English for the same terms, but with relation to many of the things that are being advised, it is against the religion of many of the people that you are trying to reach. I would like to know practical suggestions on how you can overcome the obstacles of reaching people within your communities, the obstacles within the communities, assuming we are able to overcome the obstacles about money and the ease of getting the information to them.

You brought up a very important point, and it is the nature of this that I am looking for. You mentioned that in the black community the women by and large, are being monogamous. There is a real obstacle in getting them to use condoms because they are married, and they think they are safe. Those are the kinds of things culturally. Recommending condoms to the Latino community goes against the majority of their religions. However, the strategy of recommending them for disease prevention specifically instead of birth control is often accepted by many, many priests. So, I am not as familiar with all of your sexual patterns in different cultural communities, but if you can identify what is special, what is different, how best to access your own community, what strategies need to be used, I would very much appreciate receiving that information.

CHAIRMAN WATKINS: We will close out the panel with these quick questions. Ms. Stephens, if you would provide for the Commission record reports on cases of discrimination faced by your members as a result of their seropositivity, it would be very important for us if you can reach out to other networks that you deal with and give us the best information you can. We have had many hemophilic youngsters come before the Commission. Almost to a person, they have had significant discrimination against them. We would like to have some documentation about that. You may already have this available, and if you do, if you would package it up and send it to me on the Commission.

For all of you, it would be important for us to know in our final report how easy or difficult it is for members of your organization, your population to enroll in clinical drug trials to prevent disease progression. We have heard a lot of reports. We have had hearings in New York on this, but we would like to have it from your perspective out here and get as specific as you can with us and then maybe you could just give me a quick answer here in the San Francisco area.

We don't need to have you write this down, but I just need a number. What is the waiting time average, not only for drug treatment programs for IV drug users, cocaine, crack users, other drug abusers in the San Francisco area? Do any of you have a feeling for that? We have been generally finding that it is at least 2 months normally. That goes on up to 6 months in such cities as New York City in selected areas. Could you give us any feel, just a number right down the panel, and then we will close it out? Dr. Ja?

DR. JA.: I believe I probably run the only drug program on the panel. It is probably about 1-to-3-month waiting list in most of the residential facilities. In outpatient, particularly in Methadone types of clinics, it may be longer depending on the area in which it is located. There are extensive waiting lists in all substance abuse treatment centers in San Francisco. We have a problem here in San Francisco.

CHAIRMAN WATKINS: Do any of you have any other comments to add to that? Dr. Saucedo?

DR. SAUCEDO: Yes, one other comment in relation to Latino non-English speaking, if you do not have Spanish speakers at any of the centers, then in effect even if they may be at the treatment center, it is very difficult to receive treatment, so that you don't have access at all.

CHAIRMAN WATKINS: So, it is principally not a waiting time issue in your case as much as it is the qualifications of those at the treatment centers to do the job for you.

DR. SAUCEDO: That is right. It would be both; for those that are English speakers, the issue of it being appropriate culturally; for those that are not, the issue of accessibility.

CHAIRMAN WATKINS: All right. I want to thank you all very much for coming before the Commission today. This has been a very informative session, one of the best we have had, I think, really, on education. We needed to hear this from all of you, and I think the aggregate group gives us a unique look at where we must go in our recommendations in dealing with this complex education issue that I think too many have made simplistic. Thank you very much for coming before us this morning.

[Applause.]

CHAIRMAN WATKINS: I would like to move now to Panel 2, West Coast Organizations. We have Mr. Peter McDermott, Chief Operating Officer, AIDS Project Los Angeles; Bea Kelleigh, Executive Director, Northwest AIDS Foundation, from Seattle; Sandra Long, Executive Director, Aid for AIDS of Nevada, Las Vegas; Sue Slavish, Coordinator of Infection and Environmental Control, Queens Hospital, Honolulu, and past president of the Life Foundation, Honolulu and Gretchen Miller, Willamette AIDS Council, Eugene Oregon.

Welcome to all of you and particularly you, Peter. Mr. Peter McDermott just escorted the Chairman of this Commission and the Executive Director on a site visit to a variety of AIDS Project Los Angeles programs, including the Necessities of Life Program, a very unique opportunity for getting together with all those who are afflicted with the HIV and can come to give them assistance, both in the matter of survival and food service and the like to an opportunity to get together with professional counselors and deal with the epidemic as a body. So, we welcome you again, Peter, and thank you for your assistance in the Los Angeles area a few days ago. We would like to open this particular panel with a statement from Mr. Peter McDermott.

MR. MCDERMOTT: Mr. Chairman, members of the Commission, distinguished guests, thank you for the opportunity to make this presentation. Dr. Wolfe, our Chief Executive Officer expresses his regrets at not being able to be here himself to do this. So, I take pleasure in presenting this information about AIDS Project Los Angeles (APLA). I have brought with me George Saunsel who is the Director of Client Services, who also assisted me with your tour.

I think you have a copy of the material that I provided, and I will try to briefly go through it and maybe highlight some of the specifics. The purpose of AIDS Project Los Angeles is to support and maintain the best possible quality of life for persons in Los Angeles County with AIDS and AIDS-related illnesses and their loved ones by providing and promoting public and privately-funded vital human services for them. We also seek to reduce the overall incidence of the HIV infection by providing risk reduction education and information for persons primarily affected by and at risk for AIDS, and the general public. We are also trying to reduce the level of fear and discrimination directed toward persons affected by AIDS and to enhance and preserve the dignity and self-respect of those persons by providing and promoting critically needed education to the public health, health care providers, educators, business and religious leaders, the media, public officials and other opinion leaders, and to ensure the ongoing support for all of these services by involving, educating and cooperating with the wide range of organizations and individuals in AIDS-related service provision and by supporting levels of public and private sectors to secure adequate development and finance of AIDS research, education and human service programs.

APLA was founded in 1982, by a group of dedicated volunteers who established one of the first hotlines for AIDS-specific information, and it became an incorporated organization in 1983. We presently provide the broad range of services, AIDS-related services and education programs, and these have a direct impact on the populations served by APLA, and we think, a profound influence upon AIDS and the health service delivery throughout the nation.

Some of the February statistics I thought might be of interest to you, in this past month, February 1988, we had 1577 clients, and the breakdown of those clients was Asian, 12; black 124 or approximately 7.8 percent; white 1196 or 75 percent; Hispanic 188 or almost 12 percent; Native American 36 and "other" about 21. The breakdown on gender: 1550, or 98 percent are male; 27 are female. Interestingly the classification of those clients that we serve are both AIDS and ARC. Our AIDS-diagnosed were 1019, the ARC-diagnosed were 515. We provide emergency housing and shelter. Number of clients served last month was 14, and number of nights of shelter provided, 342. We have a home care program, and we had approximately 40 clients on that program receiving 4374 hours of care, and in our mental health program which I will touch upon a little bit later, we had 163 clients, and we counseled 61. We do hospital visitations, both clients and non-clients for 414 visits, and our Necessities of Life Program which you had the pleasure of seeing, Mr. Chairman, the number of clients was 635, the orders filled, 2540. We had 163 volunteers, giving about almost 2000 hours, and milage--because APLA does cover most of Los Angeles County--was 6000 miles. In the buddy program which we will also touch upon, we served 252 clients, with a total number of hours of 7056. In our dental program we had 145 patients treated with about 349 procedures. We had 86 volunteer hours of dentistry (that is not 86 dentists but number of hours) and the staff hours were 217.

Of interest in terms of the AIDS group, we have five clients under 15 years of age, in the group 15 to 19, two, in the 20 to 24 group 69, which is a unique increase. We have had over 150 percent increase in the number of clients in the age 20 to 24 grouping. Twenty-five to 34 age group 694; 25 to 34, 555; 35 to 44, 195; 45 to 54, 45 and over age 55 approximately 12.

As I mentioned, we provide not only the emergency food, shelter, transportation and counseling services but of interest, also, for us is the AIDS in the mental health area, and we sometimes refer to this as the other epidemic. Of the 12,000 plus cases of AIDS reported in California, in the 50 to 88,000 cases of AIDS projected in California by the year 1991, persons with AIDS are 66 times more likely to commit suicide than the general public. Our organization has a 6-week waiting period for individual psychotherapy for persons with AIDS due to lack of funding, and of the amount contained in the 1987-88 state budget in California for all AIDS-related mental health services only totals about $700 thousand.

As you, Mr. Chairman, indicated, persons with HIV infection and their loved ones suffer high levels of distress, depression and anxiety due to the great degree of uncertainty associated with the diagnosis. Frequently dementia appears as the latter stages of AIDS, and as a result memory and decision making may be impaired. We think it is important that the community know that in the incidence of organic mental disorders, especially toward the end stage of the disease, dementia occurs frequently enough among persons with AIDS that a new clinical syndrome has been identified: AIDS dementia complex (ADC). Those diagnosed with ADC can experience symptoms ranging from impaired concentration and mild memory loss to delusions and psychotic thought processes. I just wanted to mention that as an addendum to the material that I presented to you.

The innovative Necessities of Life food program distribution center is one of the most unique of its kind in the nation. It provides not only groceries but high level nutritional supplements, vitamins, clothing, free medical equipment loans, counseling and support services, as well. We work with the county department of health services in operating a joint dental clinic for the AIDS patients, and it is one of the most unique of its kind and one of the first in the nation. We work closely with all existing mental health and health care providers throughout Los Angeles County. We have both formal and informal channels with direct AIDS service groups, such as Health Watts Foundation, Minority AIDS.Project, El Centro Community Mental Health, Aid for AIDS, the Shanti Foundation, Cara a Cara and the Gay-Lesbian Community Services Center. We also work closely with existing organizations, such as the American Red Cross, Hospital Council Southern California and the County Department of Health Services.

One other particular note is our comprehensive case management program. We developed a model in early 1985. We have been able to successfully employ 12 case managers, and are hoping to reduce our client case manager ratio from presently about one case manager for 250 clients, down to one case to 75. With the increased number of patients that we are getting on a month-to-month basis, that is a hope, and I don't think we will really achieve it. We were able to develop a computerized information management system which we are going to be testing with the help of funds through the U.S. Health Resources Services Administration, and we hope to be able to have computerized access to community agencies, hospitals and outpatient units throughout the County of Los Angeles to speed access by these case managers to important referral information based on client need and to bring information of client condition to case managers through confidential coding. Eventually the program will be offered to AIDS service agencies throughout the nation as a means of improving efficiency with limited resources.

Our hotline is, again, the mainstay that we started with. It is one of the busiest in the nation. We have volunteers who go through 44 hours of training, and we field over 5000 calls per month through a staff of over 100 volunteer respondents. We, also, have a telecommunications device for the deaf and a communicator which will be capable of delivering AIDS information telephone messages in 20 different languages, including many Asian Pacific languages. We have our own speakers bureau. We have an AIDS issues forum. It is like a newspaper. It now has a circulation of over 132,000, and it is published quarterly. It is becoming a standard for our community.

Overall more than 110 paid staff and 1300 volunteer workers work regularly at the Project and direct assistance to persons with AIDS. Approximately 25 percent of APLA's current active clients are persons of color, and as part of its outreach to local minority communities we employ two full-time Spanish-speaking case managers, a Spanish-speaking case aide, bilingual support staff at all levels of client interaction and black and Hispanic outreach coordinators and educators. We also produce Spanish language educational forums and radio announce ements on the subject of AIDS.

In February this past month, through sponsorship of the National Institute of Mental Health and the U.S. Center for Disease Control, we facilitated the first national Hispanic AIDS Planning Conference to be held for the benefit of Latinos who are currently striving to identify a national agenda for dealing with AIDS in their community. We, also, receive funding through local governmental groups, the city of Los Angeles, the County of Los Angeles and the city of West Hollywood. We are looking for support and are getting it from the private sector, as well through the California Community Foundation, the Ahmanson Foundation and the Flintridge Foundation.

We have been instrumental in working with the state government and through some programs that we were doing under a state grant to convince the state government to submit to the Federal Government a Medi-Cal waiver so that those persons suffering from AIDS can get home care. We anticipate this waiver will be approved and that the services will be available as of July of this coming year.

We have a variety of fund-raising approaches. Some of you may have heard about our AIDS Walk. We did it last September. It involved the total community in which we had over

8500 walkers. We, also, had our Commitment to Life benefit honoring Dr. Mathilde Krim and Whoopie Goldberg. It was co-hosted by Elizabeth Taylor and Betty Ford. It featured representatives from throughout the entertainment industry.

We will continue to expand our range of services and approaches and try to continue as a national leader in the provision of AIDS-related services and education and as a member of the newly-created AIDS Commission for the County of Los Angeles, AIDS Project Los Angeles was a member, along with the Gay Lesbian Community Services Center and other recognized organizations. We are in the process of developing a 5-year plan which should be available sometime this April, and I think you in the Commission would be interested, and I will make sure that a copy is sent to you once it has been submitted to the board and approved.

It should provide some guidance and some recommendation to the Commission on how to bring the community together and solve some of the problems that are related to governmental funding and private funding. I think with the leadership of that AIDS Commission to create a private-public health consortium, we can provide a better way of making sure the monies spent in Los Angeles County are not wasted with duplication of services and that we can get the proper education out to the total community.

We are still, as a community-based organization, needing direct support. We sometimes feel like the pipeline from the Federal Government gets closed or at least there are some glitches, in the sense that the HRSA money for our case management program which was approved back in July, received by the county in October, was finally sent to us this week. We think that is a slow way of getting the money down from the Federal Government. The AZT program to assist those persons needing AZT, also, has been slowed significantly. I just want to mention that I will be leaving the AIDS Project Los Angeles and working with a new group consisting of the Archdiocese of Los Angeles and six other Catholic Hospitals who are concerned about the AIDS epidemic and the need for subacute care for AIDS patients needing residential care in hospice. I will be heading up that organization and trying to create more resources for those patients suffering from the disease. I thank you for the opportunity to speak and present our program and the needs that we have and the recommendations that we have made, and wish you well in your deliberations to move this massive federal organization to meet the needs of this epidemic.

CHAIRMAN WATKINS: Thank you, Mr. McDermott. We would very much like to have the report you mentioned coming out in April just as soon as you can provide it to us, even in its draft form, if you feel that it is substantively complete, it would be helpful to us in preparing for our final report. In addition, I think we have already tasked you when we were in Los Angeles for a little more details on the track record of the delays in the funding process out of HRSA so that we can look at that and decide whether or not we need to find a better way to facilitate that process and not allow those delays to take place in the future. Ms. Kelleigh?

MS. KELLEIGH: Thank you. Good morning, Admiral Watkins, members of the Commission and guests. My name is Bea Kelleigh, and I am the Executive Director of the Northwest AIDS Foundation. I very much appreciate the opportunity to speak with the Commission this morning on behalf of our community's response to the AIDS epidemic.

The Northwest AIDS Foundation was established in June 1983, by leaders of the gay and medical communities in Washington State to respond to the AIDS epidemic in Seattle-King County and throughout the state. At that time only seven people had been diagnosed with AIDS in our area. Our mission is twofold, to provide the education that can stop the spread of this disease and, also, to build a network of home and community-based services to allow the thousands of people who are seropositive and will in time require care to, stay in their homes and communities as much as possible and out of expensive hospital beds.

Our social services for people with AIDS are based on a continuum of care approach that recognizes that those living with this disease need assistance with a broad spectrum of services ranging from case management and low-cost housing chore services to home health care and emotional support.

The Northwest AIDS Foundation directly provides case management services, information and referral, housing assistance and emergency financial assistance. The case management program has as its goal preventing crises such as unnecessary hospitalization and eviction.

Over the past 2 years in this program we have served 40 percent of the people with AIDS in our area; 70 percent of them primarily men but there are also women and children with this program who live on less than $400 a month; 90 percent are unemployed when they come to us, and 15 percent are people of color.

In the interests of building this network of needed services, the Foundation serves as the lead coordinating agency for the entire range of community-based social services. We act, for example, as a grant maker and funding source for the People of Color Against AIDS Network; for the Chicken Soup Brigade, which provides voluntary chore services, meals and transportation assistance; and Shanti Seattle and the Seattle AIDS Support Group, which offer emotional support. AIDS prevention is the No. 1 goal of our education programs. We work directly with gay and bisexual men, offering public education like the "Please be safe and be well equipped campaigns," workshops focusing on healthy life styles, peer support groups and trained community volunteers who help other community members make and maintain the commitment to a safe life style.

The Northwest AIDS Foundation also collaborates with multicultural groups, including the People of Color Against AIDS network, and the Women and AIDS Task Force, and the Seattle-King County Department of Public Health, and our local chapter of the American Red Cross to provide and support AIDS education within each of the communities affected by this disease.

Each of the collaborating organizations working on preventing the further spread of this disease seek to help people in their community maintain safe behaviors over time. In doing this we ask individuals to set the highest possible personal goals that are achievable and can be sustained.

For many of those who are at highest risk, gay and bisexual men, people who use IV drugs, a monogamous married relationship is neither possible nor realistic. We encourage those for whom marriage and abstinence are not realistic to use condoms consistently. In our education materials we have used language and illustrations that are straightforward and easily understood to help people substitute low-risk activities for high-risk behaviors.

This approach has been effective. One illustration is that over the past 4 years we have seen a reduction by 80 percent in sexually-transmitted disease among gay men.

In 1987, 800 volunteers contributed over 70,000 hours of volunteer time in our education and service programs for the Northwest AIDS Foundation, the Chicken Soup Brigade, Shanti Seattle, and the Seattle AIDS Support Group.

Like other communities across the country, we are concerned that the volunteer resources will not be able to keep up with the rapidly-growing need. Even in Seattle and King County with 573 people diagnosed, as of March 2, of this year, some people with AIDS are staying unnecessarily long in the hospital for lack of nursing home beds and personal care services. We are finding that people who are double diagnosed with AIDS and chronic mental health problems, or AIDS and drug abuse are less likely to have the personal support networks that help care for them. As a community-based organization, the Northwest AIDS Foundation has helped to build the beginnings of the public-private corporate partnership in Seattle, King County and Washington State that is necessary to respond effectively to the AIDS epidemic.

In this capacity, the Foundation has worked with health officials and others throughout the state to assure that AIDS education is straightforward and effective and that service programs are sensitive and responsive to the needs of real people who are affected by this disease; to encourage the high level of volunteerism, that is helping people with AIDS remain in their homes, to develop corporate support for AIDS education and care through fund-raising and corporate education programs and to work with state and local government to develop sensitive, responsible, long-term approaches to the AIDS education and care needed in Washington State. If you will bear with me for just one more moment, I have three particular recommendations I would like to make.

The first is that AIDS education and service programs must be sensitive and responsive to the real community needs. To be effective we need to be able to use language and messages that are truly meaningful to people at risk. Second, people at risk must be encouraged to come forward and take advantage of education and service programs without fear for their civil rights and human rights, and, third, funding must be available at the community level to community-based organizations who, after all, know best how to care for their own.

CHAIRMAN WATKINS: Thank you, Ms. Kelleigh.

MS. LONG: My name is Sandra Long. I am the Executive Director of Aid for AIDS of Nevada, commonly referred to as AFAN. I would like to start by giving you a brief overview of our state, our community and our organization.

Nevada has a population of about 1 million people. Its principle industry is gaming, which brings in yearly gross revenues in excess of $8 billion. Approximately 27 million visitors come to Nevada annually, giving us the distinction of being the top tourist state in the nation. Approximately 32 percent of all our jobs in the state are gaming related. Also, in the counties outside of Washoe and Clark, prostitution is legal. Las Vegas, where AFAN is based, is in Clark County, which is the largest county in Nevada. We have a population of about 600,000 people. This figure represents 63 percent of the state's population, although we have 75 percent of the AIDS cases in Clark County.

Our organization, AFAN, is a volunteer organization which began operation in 1985. Our primary mission is education and client support. Education is particularly important to our community because of our daily interaction with millions of visitors to the state. We provide a speakers bureau and conduct

AIDS in the workplace seminars for private businesses. We do AIDS 101 for civic groups and organizations. We have an AIDS telephone hotline. We have a minority outreach program. We have a newsletter, and we have a media network.

Our client support mission is, also, vitally important because the gaming industry attracts large numbers of transients and indigent people, some who are infected and have no support system. Our client services program includes transportation, hospital visitation food bank, client counseling, financial assistance, buddy program and several other programs.

We do, also, have temporary residential housing and in many cases it has saved our county over $340 a day per client because if they have no place else to go, they will not get released from the hospital, and our temporary housing can keep people up to 90 days.

We have two full-time staff positions and one part-time clerical. The second staff position was funded just last month through United Way. The rest of our members are volunteers. In 1987, volunteers donated 39,518 hours of service. If we were to pay even minimum wage, that would be over $132,000 for the services.

Our budget last year was $58,000, and our client expenditure increased over 100 percent. We served 77 clients during last year. This year we have approximately 57, and the breakdown is 11 percent black, 11 percent Hispanic, and the rest are white.

The volunteers do many things other than what I have mentioned, and it is evident that they, with all those hours given, forthis reason, we recommend that grants for home-based AIDS organizations, specifically targeted for volunteer coordinators and client service directors for every dollar spent could be returned three and four and five times.

With respect to the issue of prostitution, let me state that we are not promoting or endorsing the practice. However, in a recent article by Patrick Buchanan in The Washington Times he asserted that it is unusual for a woman to get AIDS from an infected male through normal sexual intercourse, and he uses the Nevada brothels as an example.

In the Nevada, there are 37 to 40 brothels; there are approximately 350 prostitutes working at any one time, and they each service about 10 patrons a day. That is over 127,000 a year, and there has not been one case in the 18 months of testing of HIV positive in any of the prostitutes, but there is a reason. They have a weekly test for VD and a monthly test for AIDS. Also, condom use is mandatory. There were nine women screened out in pre-employment screening for HIV positive, and of course, now they are probably out on the street blowing Mr. Buchanan's theory all to hell.

[Laughter.]

The Nevada brothels are clean, although I am not endorsing or advertising. We don't make any recommendations there. However, we don't like the misleading commentaries which relegate the likelihood of contracting AIDS through heterosexual contacts. Our concern primarily focuses on high school and college-age people who are influenced by such information, particularly since the view is aligned with what they desire to hear. Therefore, we would like to make the recommendation that we have target-specific AIDS information programs which can be taught in the homes, in churches and schools which deal with methods of protection, other than abstinence.

Finally, as part of our services we assist clients through the pondersome, burdensome, bureaucratic maze for social services, but the hearings, decisions, appeals and adjudications are all procedures that people with AIDS have little time to battle. It is not uncommon for clients to die prior to receiving their first social service award, thereby leaving their families and loved ones in debt with hospital and burial expenses and leaving them to die without dignity. We would like to make the final recommendation that we have programs established which would grant immediate benefits to people with AIDS, and it has been my privilege to address you. Thank you very much.

CHAIRMAN WATKINS: Thank you very much, Ms. Long. Ms. Slavish?

MS. SLAVISH: Thank you, Admiral Watkins. One of the things that we were asked to do in providing testimony to you today was to share with you some of the unique things that make Hawaii the state that it is, and one of the things that makes us very unique is our aloha spirit, and in that spirit we have sent from the Foundation a flower lei for each of you and the other members of the Commission who could not be here today to wish you well in your endeavors.

[The Commissioners were then presented with leis.]

Admiral Watkins and members of the Commission, on behalf of the Life Foundation Board of Directors, the membership and the clients we serve, I would like to thank you for the opportunity to speak to the members of the Presidential Commission. The March 15 press release announcing these hearings mentioned Hawaii and its unique position regarding the AIDS problem. We are unique because of several factors, including a large military population, tourism, a multiethnic population, immigration and lastly the separation of our communities because we are an island state.

All of these factors impact on any planning to control or stop the spread of the HIV virus in our state and beyond. Since its inception, the Life Foundation has tried to address these issues as it planned its programs and services. Activities of the foundation since its beginnings in 1983, include a number of different areas, and I will just give a synopsis of the things that are listed in the testimony that I have submitted.

The foundation, since 1983, has provided services to over 170 clients, including 40 patients with AIDS who were diagnosed in other communities and moved to Hawaii because of the warm climate or for other reasons.

We have, also, provided services to at least six individuals who were tourists in our community and needed assistance during their visitation. The services include support groups of which we currently have six active. We have had an HIV positive support group, but that is currently not very well attended.

The groups meet weekly and are led by cofacilitators, one of which is a professional social worker or clinical psychologist, and the other is just a community volunteer. All of these facilitators at the present time are volunteers of the association.

Individual counseling is by our client services director, Dr. Michael Bridge who has been with the foundation since November 1986, and since his arrival, he has established a program of hospital visitation of hospitalized AIDS patients of three times per week at two of the acute care facilities on Oahu. Now, there are several other health care institutions on Oahu which, also, care for AIDS patients, but because of the numbers of patients and time he is unable to make visitations to the other institutions. We have a buddy support system. Patients are assigned a buddy upon request. These individuals are trained by the foundation to perform a variety of services which may include transportation to appointments, assistance in filling out various forms for benefits including Social Security, Medicare, food stamps, etc., and helping with household chores or just being a friend.

To support the buddy program, the Foundation has trained over 200 volunteers in a 3-day intensive training workshop that is given at least quarterly and has matched over 60 buddies with patients with AIDS since starting the program in mid-1984. We also have a recreational program that is funded through donations by both corporations and individuals that allows us to provide tickets to plays, concerts and movies for our patients and our clients, and there is also a library of books and videos available. We do a large amount of education in the high-risk area. We have been doing counseling and education in the bathhouse in Wakiki since early 1985. Educational materials are provided at all fund raisers at gay bars in Waikiki. In addition, to the social activity, they get AIDS education. Bartenders working in gay bars have attended a basic high-risk education program, conducted by our foundation's health educators, and we have provided safer sex guidelines and safer sex kits are available at no cost at the bars. A total of 13,000 of the kits have been distributed in the past year. A locally oriented poster directed at gay men has been developed and distributed in bars and other appropriate locations. There has been an attitude survey of the gay community that has been developed and distributed and is currently being analyzed by the people within the foundation who did that project. A grant and aid request has been submitted to the department of corrections for an education and case management program for prison inmates. We currently have two prison inmates in the state who have been diagnosed with the disease, and many more are already antibody positive.

Outreach has been initiated with the IV drug-using community. We have a volunteer who is knowledgeable about this life style who is providing basic AIDS education and condoms to that population in their environment.

School education. In August 1985, the Foundation developed its first AIDS education program for intermediate and high school students. The first class sessions were held in October of that year. Since that time, 133 school presentations have been done to over 7500 intermediate and high school students in both public and private schools. Until the 1987-88 school year, this program was carried on entirely by a small group of volunteers.

In July 1987, the foundation submitted aa proposal for dedicated funding for the program to a number of local foundations and corporations. To date we have received approximately $35,000 to continue this work, and we now have two paid health educators working part time on our school program.

During the same time the Foundation program was being developed, there was, also, active discussion with the board and the Department of Education on the development of a curriculum for the private school system. In addition the Foundation submitted legislation for the 1987 session requesting $500,000 for the development and implementation of this curriculum. Funding of approximately $150,000 was finally approved and a mandatory 3-hour program is currently being conducted for high school students during the 1987-88 school year. We are not certain what is going to happen after the school year is over with.

Parents are, also, invited to preview the program at PTA meetings. Since August of 1985, the volunteer and paid staff of the Foundation has conducted over 170 community education programs for general public and public interest groups, reaching over 7000 members of the community face to face. We have produced two local PSA's for the radio and television market in Honolulu and throughout the state. We have sponsored two AIDS awareness weeks during November 1985 and 1986, participated in a number of educational programs, sponsored a special half-day workshop for the clergy, co-sponsored a "train-the-trainer" workshop where we brought the train the trainer people from the State of California to train individuals to do AIDS education in the community. We have also sponsored an all-day workshop for health care and general public featuring a number of AIDS experts including Dr. Donald Abrams, Dr. Constance Wofsy and Dr. Deborah Greenspan; and co-sponsored ored a presentation on AIDS and women recently in which Dr. Constance Wofsy did the oral presentation, followed by a panel of women who are considered leaders in our Hawaiian community. We also have a safer sex poster for the heterosexual population that was cosponsored by the University of Hawaii student health service group. Our most recent project for education is submission of a project to the Junior League of Honolulu to design, develop, print and distribute a locally oriented comic book about AIDS. It will target 8th through 12th graders and will be appropriate for our multiethnic population, and we will include a pidgin, which is the kind of changed English used by many of the local kids in our community. A decision about funding for this project is expected by mid-April. Military education and counseling has included coordinating with the military to do counseling regarding HIV testing, and doing counselor training for the US Navy HIV counselors. We conducted AIDS education at the Kaneohe Marine Corp Air Station for approximately 3000 marines. We have conducted AIDS education for civilian support staff at the U.S. Army base at Fort Shafter, and we have assisted the public relations personnel at Hickam Air Force Base to develop an educational material that was distributed to all Air Force personnel in the Pacific.

We have, also, been active in legislation during the past three sessions. The Foundation has authored a number of bills relating to discrimination, confidentiality, informed consent for HIV antibody testing, mandatory AIDS education and other issues, and we remain very active in the legislative scene. Other activities that the foundation has participated in include the establishment of the Mayor's Commission through the work of Dr. David McEwan who is one of the founding members of the Foundation. Active participation in a community consortium to obtain funds for a residential facility and a case management program for the AIDS patients, and through that consortium we have already been able to develop a Medicare waiver so that effective now, we can provide home care for patients through Medicare waiver, care that was only available in the acute care setting before this. We facilitated formation of two additional foundations, the Maui AIDS Foundation and Kauai Shate Project and provided a place for individuals doing community service associated with courts and corrections to do volunteer work for the foundation.

Our concerns at this point in time include the ability to meet the needs of our diverse multiethnic population which includes Caucasians, 26 percent, Japanese 23.5 percent, Filipinos 11.2 percent, Chinese 5.1 percent, Hawaiian or part-Hawaiian 18.9 percent and representatives of Somoan, Tongan, Vietnamese, Hispanic and black or Korean nationalities making up the last 15 percent.

Our population is slightly over 1 million, and the 1980 census indicated that 226,000 people spoke a language other than English at home. Therefore multilingual educational material is needed but because of our limited budget and the size of the organization it is very difficult for us to do this because of the expense involved, and we would be very interested in seeing broad-based multilingual educational material available.

Education of tourists and the tourist industry is also of concern. The Hawaii Visitors Bureau and other influential members of the tourist industry have been reluctant to become involved because of the possibility of negative publicity, but with the annual visitor count of over 5 million of whom 1 million come from Southeast Asia and the Pacific Basin, the industry's involvement in a proactive way is imperative, and we would appreciate some guidance perhaps in encouraging them to do this.

The difficulty or inability of community-based agencies to obtain funding in a variety of areas but particularly for patient care needs has been even more evident in Hawaii because of application for many grants was based on a minimum number of patients rather than cases per capita. Despite having only 213 cases diagnosed in the state, the state is seventh in the nation on a per capita basis for the number of cases of AIDS.

Difficulty in providing client services to people living on the neighbor islands is, also, a problem for us and a concern; because we are separated by bodies of water between the islands, it becomes extremely expensive for our educators to go to the neighbor islands or for the patients to come to Oahu where many of the services in health care are available to them, and

Oahu may be the only place that they can receive some of these services. We thank you for the opportunity to testify before the Commission.

CHAIRMAN WATKINS: Thank you very much, Ms. Slavish. On behalf of all the Commissioners, I want to thank you for these lovely and traditional leis. Mrs. Watkins and I had two wonderful opportunities to live on beautiful Oahu during my 37 years of commissioned service, and we are very fond of your islands and fond of your people there, and we very much appreciate your special gesture on our behalf today. Thank you. Ms. Miller?

MS. MILLER: Admiral Watkins and members of the Commission, I appreciate the opportunity to testify. I feel fortunate to testify right after Ms. Slavish, since I get a much more colorful group to look at than anyone else did.

CHAIRMAN WATKINS: You could have presented us with some salmon, Ms. Miller. It would be perfectly appropriate. It might have been a little conflict of interest but not a lot.

[Laughter.]

MS. MILLER: I can tie it in. Next time, smoked salmon.

[Laughter.]

MS. MILLER: I am here representing the Willamette AIDS Council which is a community-based organization in Eugene, Oregon. Eugene is a community of the greater metropolitan area of about 200,000 people. Willamette AIDS Council covers to the extent you can call it that or the extent we can a larger geographic area from the mountains to the ocean and from somewhere north of Eugene south to the California border. So, it is a pretty good sizeD territory. We have a comparatively small seropositive population. Of course, we have a comparatively small population, too, but statistically the percentages are fairly low. I would say that we are fairly early on the epidemiological curve compared to the big cities on the West Coast, compared to the big cities in the East for that matter. It is our intention to stay that way. That is where we want to be is lower on that curve. We have a lower percentage of infection among gay men who are tested than you will find in most of the larger cities. We have a relatively low seropositivity rate among IV drug users, at least so far as we have been able to tell. That is a difficult population to capture and test sometimes. It is our goal to do the best we can to keep that rate fairly low. Our infection curves are rising. Our doubling times are stretching out and slowing down a little, not as much as we would like, and it our goal to try to keep the epidemic, if we can, at a somewhat earlier state than you see in the bigger cities.

One of my important thrusts here is to point out that AIDS is in every community, that it is not a big city problem, and it is not in any way limited to San Francisco, Seattle or Los Angeles. After listening to these people testify, and comparing our organization to theirs, I feel that ours is built more on the PTA model than theirs are. We are not into the major corporate kind of organization, not that we wouldn't like to be, if we could, but we really do run much more like any church group that you have ever worked with than we do like a large corporation.

There are some particular issues that we have to deal with working with smaller communities, and these are not issues peculiar to Eugene or to Oregon; these are issues that I think you ought to remember across the country. There is a tremendous burden on the family physician, on the local hospital, on the local nursing home as soon as there is one AIDS patient in town. The family physician already was busy enough. Now, there is an entirely new problem. Where do you go to get information? How much time can you spend scrambling for it? How do you have the time to provide compassionate care to the family? Where do you get the time to set up community meetings to reassure people that they are not going to be infected by casual contact? All of that is going to be uncompensated care, and that is what people do in the small towns. That is the kind of pulling together effort. So, you call into Eugene and Portland and you try to get somebody to come down from the state and you put these meetings together and no one is compensating for that kind of time and effort, and nobody is really providing a way to expedite it. The wheel is being reinvented in 10,000 communities all over the country because nobody has been able to really coordinate that effort.

Referral patterns are a problem medically. In some situations certain kinds of care will simply be unavailable. There will be no dermatologist who will someone with AIDS. There will be no dentist, and you have a dental problem, "Well, there is a big city 500 miles away. Try going there." This is not much of an answer for the person who is HIV positive. The other response you can say is, "Well, lie. Don't tell the dentist." I couldn't tell somebody to do that. I couldn't encourage anybody to do that, but what are their options? There are genuine major problems. There is the person who may be exposed and who is worried, and quite literally, if you are a gay man or an IV drug user in Deadwood, Oregon, you have no support system. There is no one to whom you can go and ask questions, get straight information, just get sympathy, encouragement, support.

So, we try. We have tried from time to time to send a circuit rider out to the smaller communities to provide that kind of support and human contact and encourage people to come into town when they can. For an organization that works like ours does, it is very difficult to send a circuit rider around. It is a long way. There are not very good roads necessarily. Even if they are decent roads, Goose Bay is just not very close to Eugene. It is a several-day trip, and we just are out raising, quite literally, having bake sales and raising money to buy gas for somebody so that they can take a few days and make one of these trips, and somebody tries to get around to the smaller communities several times a year, but it is a very makeshift program to try to be fighting an epidemic. Bake sales just do not seem somehow like the way we ought to be putting this together.

It is hard to find these people. Before you can even circuit ride, you have to find them, and in small communities, since there is no at-risk community, one way of looking at it is to say that the gay people and the drug users are well integrated into their community or the other way to look at it is to say that they are hiding, but whichever way you look at it, it is not going to be easy to find these folks to identify them, and the man who is a long-haul truck driver who became infected when he had sexual relations while he was out on the road for 2 or 3 weeks and has a wife and five kids at home is not going to be making himself easy to find to provide services to him, either before or after he is infected, and that is the kind of situation we confront.

Let me take just a moment to mention a big concern, one that we know we haven't dealt with adequately, and that is gay teenagers. It is hard enough for our workers, our gay men who are volunteers, to work with other gay men. They can try to make it a joke, and they can bring the condoms around and in your manilla envelope you have one of our condoms in its safer sex wrapper that the state health division buys the condoms, and we print the wrappers and tape it all together, and they can go out, and they can give these around, and they can joke about it and kind of ease people over the embarrassment and volunteer to help put the condom on, if they aren't quite sure how to do it and kind of get them joking and talking. A gay man cannot go within 20 miles of a gay teenager and present that kind of explicit friendly, joking information, but the teenager is not going to get that message from you or from me. It has got to be somebody who can communicate in that direct way, and our society is such we don't want to admit these kids exist, and we certainly don't want to have gay men within arm's reach of them. It is a problem we have been trying to confront, trying to work out some programs to deal with. Those gay teenagers, it is clear to me, are the source of the infection when we see the 20 to 25 year olds who are coming down with the disease. They didn't get it when they were 20. That seems pretty clear.

We are very inclusive in our organization in Willamette AIDS Council. I think everybody tries to be. It is clear to us that we have no choice. We are not big enough to exclude anybody. You cannot have support groups for all the different potential communities because support groups by definition need more than one person. So, it is pretty broad based. We have worked with the Chamber of Commerce a lot, putting together posters. You have a poster in your manilla envelope, too, putting together a conference for employers, sending speakers out to employers and personnel directors, sending speakers out to the unions. We have sent speakers out to the Gospel Businessmen's Breakfast Hour. We have sent speakers out to schools, the Rotary Club, anywhere, anywhere you can get two or three people who will hold still, we can find somebody who will go out and make a presentation to them.

We went to the county fair. We gave helium balloons to the kids. I couldn't bring helium balloons on the airplanes. You have the unblown-up balloon in your packet. If you want me to blow it up with air over lunch, we are versatile. I will do that.

[Laughter.]

We gave away condoms to the people who looked old enough as if they would appreciate a condom. There is sort of a little bit of subjectivity in who gets the condom and who gets the balloon, but if you are too old to really think the balloon looks like fun, we will offer you the condom instead, lapel pins, AIDS quizzes we gave out at the fair. We printed up coasters to go to the bars, along with the condoms so that if people didn't see the condoms on the counter, every time they ordered a drink they got a coaster underneath it for the table. All of this as a way to get to people. This is low tech. This low case outlay. This is all volunteer, but it needs a little bit of cash outlay. We need a little bit of volunteer coordination and this is everywhere. This is in small towns all over the country. You cannot just do this strictly on volunteers. So, we have an underpaid half-time staff person who really works underpaid full-time, somebody to coordinate this, and what I think we need is to see somebody coordinating this kind of effort in Eugene and LePine and in Mound Ridge, Kansas and Pennington Gap, West Virginia and everywhere across the country. We need a little bit of input into these low-tech efforts to educate and to work on behavioral change because the problem isn't somebody else's problem. We are all in this together. Thank you.

CHAIRMAN WATKINS: Thank you very much, Ms. Miller. We will open our questions now. We will give Dr. SerVaas, who arrived late, a chance to take a breather, and we will start with Dr. Crenshaw.

DR. CRENSHAW: You bring up a lot of good points, Ms. Miller, and I particularly appreciated two of them. One is the discrimination with regard to condoms based on balloons versus those who look like they were likely, particularly since they don't come sized for most young teenagers, don't fit into adult condoms. I guess condom companies don't think a condom labeled small is very marketable.

In relation to the worried well that you mentioned, I personally want to keep people just worried enough to stay well. So, I don't view that as a pejorative term, and it seems to me that all of you are dealing with helping to protect the worried well or getting, again, them worried enough to stay well, and I, also, appreciated your comments, Ms. Long on the counterproductive value of marketing the concept that prostitutes don't get infected, and men cannot get it from prostitutes or vice versa.

The one thing that I have recently learned that I would appreciate your telling me is that some comprehensive laws have just been passed in Washington, have they not? Could you describe those for the panel? I believe that information just came out yesterday.

MS. KELLEIGH: Our legislative session concluded on March 12. It included a means to set up six regional AIDS networks that would encompass the entire state along existing department of social and health service boundaries. Those networks will be responsible for the range of services from education and prevention counseling, testing, home-based care, working with hospitals and home health agencies. The health department in the most populous county will take the lead on this and involve in the same way that we have done in King County again, hospitals and voluntary agencies, other kinds of community and home health care organizations that are needed to do, again, the breadth of service that is required.

It also provides for anonymous testing across the state. It provides protection against discrimination for those who are HIV positive and symptomatic and those who are perceived to be HIV positive and those who are but do not yet have symptoms. It is a very controversial piece of the legislation. It also provides for prevention against using the antibody test for purposes of employment. It provides for education of school-age children beginning in the fifth grade, and it sets up an Office of AIDS at our Department of Social and Health Services who will be responsible for seeing that all of these activities are implemented across the state. The last thing that this does is require DSHS to provide education for the state workforce.

DR. CRENSHAW: Thank you, and Mr. McDermott, I would appreciate some of your thoughts and comments, having worked in Los Angeles for so long and now moving over to advising and helping the Catholic community. It is my perception that many of the apparently disparate approaches and views between the Catholic community and the non-Catholic community aren't as far apart as they appear.

Can you make some comments on how we can all work together better because obviously you are an example of that?

MR. MCDERMOTT: I don't know how much of an example I will be, but I will try. My baptism, when for coming to work for APLA, was when one of the newspapers in Los Angeles ran a headline saying that our Archbishop Mahoney condones condoms, and after three press conferences and a few other activities I was made aware that the AIDS Project has been working with the church and particularly in the Latino community to get the education out to those communities, and while the church philosophy on this subject is not my purview, the issue that we were trying to get in terms of getting education out to the Latino community was greatly facilitated by the hoopla that went around this argument of whether or not the archbishop supported condoms. The role that I want to play now with the church groups and with the Catholic hospitals is to help support the great need for people requiring subacute care in the treatment of the AIDS patient. There are a great many periods of time when they are not sick, sick enough to require hospitalization or sick enough to require attendant care, but they do go through episodes where they do need some of that care. What I want to be able to do is create a network working with not only the Catholic hospitals but the hospitals throughout Los Angeles and provide a relief for those hospitals to get those patients out of the hospital sooner because right now when the State of California put out an RFP for nursing homes to care for AIDS patients no one came forth. There were no nursing home beds available for AIDS patients. There were only two facilities that did indicate they would provide a few beds, and they were connected with hospitals, and that was their source of getting the patient out of the hospital.

So, what I am trying to do is not necessarily provide nursing home care, but subacute care at some level, down through residential care and hospice care for those people who don't want to go back to the hospital.

DR. CRENSHAW: Thank you.

CHAIRMAN WATKINS: Dr. Primm?

DR. PRIMM: The seropositive rates among your intravenous drug users, Ms. Miller, you had indicated are low in Oregon. My concern was are these native Oregonians or are they people who have migrated to Oregon and are they being targeted? You said that they were hard to get to, and we find that in almost all the cities, but I think that you have to make a special targeting to that group if you want to keep those seropositive rates low.

The other thing is I was wondering about Hawaii, what the seropositive or seroprevalence rates are among intravenous drug users there, and, also, there have been a number of studies done on prostitutes and the sex industry in Nevada, and until this day I have seen no reports of any of them having HIV positive status. I kind of got lost when you talked about that, and would you talk about that?

MS. LONG: Prostitution is only legal in our rural areas. If you have got more than 200,000 people in the county, then prostitution is illegal. So, the only prostitutes that, of course, that we would have any statistics on would be the legal prostitutes in the brothels.

DR. PRIMM: You say that if it is less than 200,000 people in a county, then it is illegal?

MS. LONG: No, it is legal if there are less. If there are 200,000 or more, it is illegal, so that Reno and Las Vegas, there are prostitutes, to be sure, but it is not legal, and Nevada passed a law last legislative session. It is AB550 which is aimed at illegal prostitution, and this bill, this law says that if a prostitute or a guy pushing his girl is picked up soliciting, then it is mandatory to have the AIDS antibody test. If she is positive, and if she is picked up again soliciting, then it is a $10,000 fine, 1 to 20 years or both.

MS. MILLER: Thank you, Dr. Primm. I don't know where the seropositivity got into the IV drug community in Oregon. I know it is certainly in the indigenous population, and we have got the doubling times indicating that it seems to be there for good. There is certainly heroin and cocaine in the state. A very major drug of abuse is methamphetamine; so it is a little bit different demographics with a slightly different problem in some respects, and yes, the state, various programs are working on mostly hiring ex-users, people who have lived on the streets, sending them back out with bleach and educational programs to try to make that kind of outreach. That has been done in the larger communities in the state, and we have had some resistance in some of the rural parts of the state. We have had some police chiefs say basically that this is condoning drug abuse, and if they find those outreach workers in their part of the state, they will arrest them. So, we are still working through those issues. In the big cities though that is starting.

DR. PRIMM: How are you getting your seroprevalence studies on intravenous drug users, through the jail or when they come to hospitals; how is that taking place in Oregon?

MS. MILLER: How are we getting them all?

DR. PRIMM: Kris?

MRS. GEBBIE: Some of them are coming into our alternate sites at local health departments. Some of them are tested when they have contact with the treatment center. We, also, just did a major seroprevalence survey in our prison system, and many of those people were identified as having a history of drug abuse. So, it is derived from all of those sources.

DR. PRIMM: What is that seroprevalence rate now? Do you know? Does anyone know?

MS. MILLER: The last I heard it was just a few percent. It was single digit numbers.

MRS. GEBBIE: Around 1 percent, I think is --

MS. MILLER: I heard 2 maybe; so, it is pretty low.

DR. PRIMM: In Hawaii what is it?

MS. SLAVISH: I am sorry, Dr. Primm, I don't have the seroprevalence statistics, but I can get those through the Department of Health. They would have them through the alternate test sites and possibly working through DASH and the prison system where they are now currently screening some of the inmates for that for HIV positivity. So, we will look for those and send them to the Commission.

CHAIRMAN WATKINS: Dr. Walsh?

DR. WALSH: When I was in Hawaii a couple of months ago, I had the opportunity to appear with many of your colleagues in your group, and I was intrigued by something that Dr. McEwan and Dr. Diamond and those are interested in, and that was the plan for what they chose to call conditional testing. Has that gotten anywhere to your knowledge?

MS. SLAVISH: Not that I am aware of. There are several bills in the legislature right now, but we are not complete. The session won't be over for several more weeks. So, they have just crossed over from one house to the other, and I am not certain at this point. There is a great deal of interest on the part of the Director of Health and the Health Department in expanding our testing, and I believe there is some activity for hospitals in the community through the Federal Government to do some seroprevalence on an anonymous basis, and in fact, the medical center for which I work has just recently submitted a grant, an RFP to become one of the institutions in the community to do that, along with Copiolani Children's Medical Center.

DR. WALSH: I know Dr. Lewin has a federal grant request in on a study, too. Are you doing any outreach to the Pacific Rim Islands in your proximity like the Marshalls and Samoa and so on?

MS. SLAVISH: We, as an organization are currently not doing that. The state is beginning to do that or to look in that arena, yes.

DR. WALSH: Very good. Ms. Miller, are you getting enough help from the state health office?

[Laughter.]

MS. MILLER: I will leave now. In all honesty, I get --

[Laughter.]

DR. WALSH: I notice you are doing a lot of private fund raising, and I am wondering --

MS. MILLER: In all honesty, I would have to say that we have not had to fight the bureaucracy to speak of, and from what I have read all over the country, I wish more people could say that.

DR. WALSH: I think you should take advantage of the fact that we have to make a lot of positive recommendations, and she has got to sign off on them. So, you really have her in the cat bird seat. You can really move now.

CHAIRMAN WATKINS: Dr. Lilly?

DR. LILLY: I will start with a comment here to get to what I want to ask about. As a gay man I have been accustomed to being part of a special population, and I now find that with respect to the organization of today's program, I am not a special population. There are other people who are special populations who consider the gay population to be what one has to distinguish one's self from. I am now relieved to find that at least a few of you have mentioned the continuing need to deal with the gay population, that the gay population may not have been taken care of in that sense and still needs attention. So, I would like a little bit of comment on that.

There is one thing that you said that I would like to bring up particularly with respect to the need to get information to gay teenagers that we cannot have a gay man dealing with them. How do we provide role models for gay teenagers if the adult gay population cannot have anything to do with them?

MS. MILLER: Bingo. I wish I knew. I think it is a horrible situation. I think it is an impossible bind that we are putting ourselves in by saying that if a gay man is anywhere around a gay teenager, and they talk about anything having to do with sex, it must be abuse, and societally we look at it that way. It is an impossible bind. We simply cannot deal with it that way because that is the only source of role models. Those are the only people who can really get the message through. You are absolutely right.

DR. LILLY: I was startled with that statement, and I have been pondering it ever since.

MS. MILLER: It is not that they cannot in some absolute sense. It is that legally and socially it is very risky. You have to handle it very carefully and be prepared for some real backlash, including some legal problems, if they are in a particularly benighted area. So, it is tricky.

MS. KELLEIGH: I think this is one of several areas where we need more national leadership. We have laws coming out of Congress now that say that no federal money can be used to promote or encourage homosexuality. Yet we know, I believe that approximately 10 percent of the people in this country will be gay men and lesbians. We have a situation where we have, if we want to prevent this disease we are almost specifically prohibited from dealing with youth who will be gay, you know, at the risk of losing a substantial amount of funding that is needed for many different kinds of services, and I think this is one area where we are saying one thing and doing another, and if we want to stop this disease, we need to be more consistent.

DR. LILLY: I will pass. We are running behind.

CHAIRMAN WATKINS: We would like to close out as close to 12:30 as possible. So, if the Commissioners have questions that we cannot dialogue on today, we certainly want to pose those questions to the panel and ask them if they would respond to us in writing so that we can complete out our hearings with you. So, Mrs. Gebbie?

MRS. GEBBIE: I will pose a question and ask for some written comments. The last panel provided some very provocative and troublesome discussion of the whole issue of how do you prepare materials that work at a community level and really a community defined quite small or narrowly defined without running afoul of bureaucracies that are afraid of explicit materials or are culturally ignorant or whatever all the possibilities are. Yet if money is going to flow from the Federal Government as lots of people want, it is going to have to flow somehow through some channels. From your various perspectives, I would be very interested in learning how you could see structuring something sensible that allows the money to flow but still gets at the diversity which you, too, have represented from your different communities and different experiences that would give you the flexibility and openness to do what you need to do for your people, some written comments on that.

CHAIRMAN WATKINS: Dr. Lee?

DR. LEE: The role of a Commissioner is a journey towards enlightenment, and I would like to know from the printed materials you submitted, how, in Hawaii, a razor is used as a sexual toy?

[Laughter.]

DR. LILLY: Are we up for this?

[Laughter.]

MS. SLAVISH: I have no personal experience in that area, and the guidelines that you have there, Dr. Lee, are given specifically to gay men or gay and bisexual men along with the safer sex kits that are distributed at the bar. So, without talking to my health educator, I cannot personally answer that.

DR. LEE: We will let that one drop. Second of all, you all are from places where our sex expert, Dr. Crenshaw, likes to refer to as places where there is "sexual tourism." Now, in Las Vegas and Beverly Hills and the Great Northwest and certainly Hawaii, all we see are pictures of incredibly beautiful naked people lying around having a wonderful time.

MRS. GEBBIE: In the Northwest they would have goose bumps.

[Laughter.]

DR. LEE: Yes, cancel the Northwest. But say in Nevada or Hawaii in particular, wouldn't there be a move, given the environment we have got to downplay your advertisements for why people go there? I mean I have never gone to Las Vegas because I know it is "bad," but couldn't you put forth a different image? I mean is there a move to do that?

MS. LONG: I am sure not. The advertising and the things that you see are bringing in annually $8 billion, and no, I think they are trying to make it quite attractive. We do have a problem because as an example, Cats, the Broadway show will be appearing at the Aladdin Theater in April and the owners wanted to make it a charity benefit, but they didn't want to make it an AIDS benefit because that might scare away the tourists. So, that is the kind of problem that we have got; it is "let us push it under the rug," and "let us not say too much about it because it might scare somebody,"

Talking about sexual toys, Dr. Crenshaw was talking about condoms. I happened to be in contact with the Brothel Owners Association to prepare my testimony, and I asked them what kinds they did use in the brothels. They use only American made and only latex, and there are three brands. One is Mentor because it adheres to the skin and doesn't come off. So, that might be the answer for the younger people. Also, there is Nonoxinol-9, but the girls and the patrons like the regular Trojan with astroglide lubricant. So, there you are, and these are stress tested, 127,000 times a year.

[Laughter.]

DR. LEE: But ma'am, you have an income for 1 million people of how many billions of dollars for your gaming industry?

MS. LONG: Oh, $8 billion a year.

DR. LEE: For 1 million people you have got $8 billion a year, and a lot of this is predicated on pumping up the sex industry in Las Vegas, and I just wonder --

MS. LONG: Oh, not at all.

DR. LEE: I just wonder if there is a move out there to downplay this.

MS. LONG: No, I guess our advertising is fairly sexy. However, as I told you, prostitution is illegal in Las Vegas and Reno, and as a matter of fact, that is how our sheriffs keep getting re-elected, because they keep cleaning up prostitution. Now with our AB550, the prostitution bill, actually Nevada is also a very conservative state, and they have tried to kill the prostitution law, but the boys in the back room and the big boys realize that that is, also, revenue. Did I answer your question?

DR. LEE: Sort of. Any statement from Hawaii?

MS. SLAVISH: The visitor industry there is just beginning to realize that they need to do something about that. The Foundation had approached one of the larger hotel owners in the state who also happens to be a physician, at least 6 to 8 months ago regarding the possibility of the placement of condom machines in the restaurants and social clubs within his facilities, and possibly, also, within the little gifts that are given out in the hotel rooms, adding a condom to that, as well, and he was not at the point in time where he was willing to do that, and they are very much afraid that, regardless of how they advertise the community, if they become associated with the disease, that it is going to drive the tourists away, and it is not just Hawaii that is concerned about this. This is every tourist community internationally because we just had a group in Hawaii last Friday discussing the very issue, that Pacific Rim Basin tourism is extremely popular right now, Australia, Japan, all over the Pacific Basin, tourism is growing, and yet they are at this point very uncomfortable with dealing with the issue and are just now beginning to provide multilingual information for people who are going to be traveling into that part of the world, and they don't want to play it up too much. So, I think we have some work to do, not only local organizations, but possibly within the government itself of the community.

CHAIRMAN WATKINS: Dr. SerVaas, we have time for one quick question.

DR. SERVAAS: Just a quick question to Ms. Miller or Ms. Slavish. In your volunteer operation there, do you have any volunteer groups in your state or do you know of any volunteer groups, any of you who do free confidential counseling and testing for AIDS in Planned Parenthood groups or in church, young family home builders groups and churches or anywhere where they include testing and counseling together on a volunteer, free confidential basis? And then, in any of your states, do you require blood banks to do pre-test AIDS counseling before doing the AIDS tests?

MS. SLAVISH: In Hawaii we do not have volunteer organizations doing voluntary testing and counseling because the State of Hawaii has an excellent program in that arena. We have multiple centers where people can go, including the University of Hawaii, the medical center for which I work and a number of other places. So, there is a lot of that. The blood bank does tests, but they don't do counseling in the same way that you would get it if you went to an alternate test site, but they have still done a lot. They provide a lot of information about the disease but they don't do the in-depth counseling that goes on in the alternate test sites.

MS. MILLER: I know that church groups in our area have dealt with AIDS and HIV positivity as an issue. They don't do the testing and counseling themselves in an individual way. There is at least one voluntary clinic that does it for people who want to go there, and the state, also, provides it. So, it is readily available, and they simply make that reference known as part of their educational program. I don't know anybody else who actually does it themselves.

DR. SERVAAS: You don't have that long waiting period in Oregon?

MS. MILLER: No, there is a little bit of a wait, but it is pretty quick.

MR. MCDERMOTT: In Los Angeles County we have opened additional centers. We had initially two major ones. I think there are now five in which there are confidential test sites, as well, providing counseling both pre- and post. There are a number of other private groups that have opened up for a fee those types of services, as well. We provide some of this information through out hotline services so that if you want to find out where you can go to get tested, both confidentially, anonymously, etc., by calling our hotline we can make referrals. One of the obligations then for us is to verify that those are appropriate test sites. So, we try to periodically check them out as well as required before we do give out information, some degree of understanding of what services they provide, who are the people that will be doing the counseling, what type of credentials do they have to do that counseling, and we will try to verify it with them to make sure that it is appropriate. So, there is no real long waiting time. It used to be a few months ago but not today to my knowledge.

DR. SERVAAS: Thank you.
MS. KELLEIGH: I might just add that our Planned Parenthood in Seattle in King County is beginning to offer testing with counseling to low-risk women. We have testing available again with counseling at the Seattle gay clinic, in addition to our very good health department facilities.

MS. LONG: We have no free testing in Nevada that I know of.

DR. SERVAAS: Thank you.

CHAIRMAN WATKINS: Thank you, panel members, very much for coming before us today. I think you are all to be commended for the very imaginative and aggressive program, particularly you in the West Coast organizations have engaged in. We have been very impressed with what we see and the imagination and the diligence which your organizations have applied to the epidemic. So, thank you, again, for appearing before us, and thank you, again, Ms. Slavish for the lovely leis.

For the Commission, in our normal customary fashion, we will waive lunch for lack of interest, and those of you who must have it, feel free to get up and go out and grab your sandwich and come back. I would like to proceed with the next panel.

We have an individual testimony coming before us, Mr. John Wahl, attorney of San Francisco. I received a letter from the general manager of the Downtown Association of San Francisco that suggested that the Commission should listen to Mr. John Wahl, and I wrote him a letter sometime ago saying that when we came to San Francisco, we would invite him to appear. We have done this with other individuals who have asked to appear before the Commission, and when time permits, we allow that.

Hopefully we can wrap it up close to 1 o'clock for questions from the Commission. Mr. Wahl?

MR. WAHL: Thank you, Admiral. Admiral Watkins and Commissioners, for the better of a year I was co-chair of the National Steering Committee of Mobilization Against AIDS, which is a grassroots organization formed to advocate action when state and federal governments were doing little or nothing in research, education and treatment concerned with the AIDS epidemic.

I have been a community activist for many years, currently serving on the boards of the Council on Religion and the Homosexual, the San Francisco Council of Churches and the San Francisco Night Ministry. However, my testimony is my own and does not necessarily represent the view of any organization.

I speak to you today from a point of view which is probably different from any you have heard in your formal proceedings. I am a gay man, openly gay and happy to be who I am. I do not see my sexual orientation as a drawback, defect, disability or demerit. I am unique as I have been created, just as each of you is unique in your difference from me and from each other. The only difficulties that my homosexuality, my gayness, causes are artificial difficulties created by those people in society, who are hostile to gay, lesbian or bisexual people.

Discriminatory laws and economic policies have historically been imposed on gay, lesbian and bisexual people. Laws have long been used to make same-sex sexual activity criminal, even though approximately ten percent of the population are only sexually attracted to members of our own sex.

Economic policies have long been used to punish our people. Homosexual and bisexual people lose their jobs in many parts of America if our sexual orientation is discovered, and we cannot get other jobs. We face eviction from rented houses or apartments or refusal to rent to us, except for enlightened areas, like San Francisco, where such discrimination has been made illegal.

When the AIDS epidemic began and when it became clear that AIDS was primarily a threat to gay and bisexual men, it also became clear to many of us that the epidemic would be used to reinforce discriminatory attitudes against us. And, of course, there are many people who have tried to do just that. We have been bullied by individuals and groups, principally on the far right, who have made the illogical and malicious charge that homosexuality is the cause of AIDS and/or that AIDS is God's punishment for being the way we are made: homosexual or bisexual.

These individuals or groups then call for quarantine or internment of us or, at least, those of us who may test positive for the presence of the AIDS antibody.

I am here today to outline a clear and present danger, which is presented by the use of the AIDS epidemic against the gay community. That danger is potentially as great as the danger presented by the virus itself. The danger I speak of is the danger inherent in the alienation and disaffection of potentially millions of people.

Gay, lesbian and bisexual people no longer believe, nor will we pliantly accept, the discredited old notions that we are somehow defective and must hide who we really are. We insist on our right to live just as full a life as you live. We insist on living a full, responsible, sexual life. We will not accept second-class humanity anymore, nor will we hide a basic aspect of who we are.

Many of us are committed to fighting for equality and as more and more of us realize that we don't have to accept the homophobic attitudes, it becomes impossible to suppress us without grave social location.

Homophobia and biphobia are clearly just as much of an obnoxious obstacle to human progress as is racism. We all know the horrendous struggles, including our own Civil War, that have been directly or indirectly related to racism. Should sexual orientation become another violently divisive factor in our society? Of course not. But there are a number of people who apparently are prepared to let sexual orientation become such a violently divisive factor.

This Commission is in a good position to work against the misuse of fear of AIDS, as a tool for those who want to suppress gay and bisexual people. The AIDS epidemic will not destroy our liberation movement, but attempts to misuse the fear of AIDS to suppress us will be very destructive to social peace. For that reason, it is clearly in the national interest to work against such misuse of fear of AIDS.

Finally, I want to talk about responsibility. Our people, as most of you know, have been in the forefront of efforts to prevent the spread of the virus. Our organizations began the work of educating our people concerning safe sex, and even now we run into governmental resistance to this kind of education. This Commission should not, for one minute, shrink from its responsibility to promote safe sex education.

To deny Americans safe sex education because of somebody's ideological or religious views about who should have sex, means that one is willing to expose Americans to lethal risks, rather than let them know how to have sex safely. Sadly, there are many people who are willing to do just that. I hope that this Commission will condemn that kind of dangerous obstruction to public health education. Those who obstruct safe sex education can fairly be said to be responsible for any disease and death which results from lack of safe sex knowledge. Thank you for the opportunity to address the Commission.

CHAIRMAN WATKINS: Thank you, Mr. Wahl. We will start the questioning on this side with Dr. Lee.

DR. LEE: I will yield my time.

CHAIRMAN WATKINS: Mrs. Gebbie.

MRS. GEBBIE: I am not sure how to frame the question. You have expressed very clearly your viewpoint and I appreciate that. I don't know if you have been here this morning at all. Did you just arrive or have you heard any of the discussion?

MR. WAHL: Just for the last -- I guess, three-quarters of the last panel.

MRS. GEBBIE: Well, one of the issues that has been in front of us today, started by the previous panel that you did not hear, is the struggle with allowing diversity and allowing materials that are suitable for small groups, small communities or specific ethnic groups' communities and some of the different ways of creating sexually explicit material appropriate to communities without running into what feel like inappropriate bureaucratic road blocks and from your view may be, in fact, this overall homophobia or something.

Do you have any insight on how to structure that process of funding that allows money to flow from somewhere to somewhere -- and people always want oversight when they are making money flow -- and still leave room for that diversity. How would you assure that money is wisely spent, even though it might be spent very differently in lots of different places?

MR. WAHL: Well, I think, Mrs. Gebbie, there are two specific instances that come to mind in response to your question.

Number one is the Helms Amendment that was a tragic mistake, enacted by the Congress, an amendment to the continuing resolution to provide funds for Health and Human Services and the CDC. That amendment disallowed any money that could be considered in any way to be spent on anything to do with homosexuality or to promote homosexuality. That is something that can be interpreted in such a way that any safe sex materials having to do with homosexual sex are verboten.

Beyond that, the Harvey Milk AIDS Education Fund, which is a tax-free, non-profit foundation that we set up in this community -- the Harvey Milk Lesbian and Gay Democratic Club set it up -- has been publishing a booklet called "Can We Talk" for many years. This booklet, I think, can fairly be said to have prevented the spread of the virus. It is one of the many devices, the works, good works, in our community that have prevented the spread of this epidemic and saved the taxpayers money.

The Postal Service has been refusing to allow those booklets to be sent through the mails to other areas. Now, this is -- in my opinion, this kind of activity is destructive to the public health and is conducive to the spread of the virus.

You have a direct correlation between somebody's idea of morality and the spread of this virus. I think that the Helms Amendment should be repealed in the interest of the national health, in the national interest, if you will, and I think the postal service should be instructed not to prevent the spread of booklets, which prevent the spread of the AIDS virus.

MRS. GEBBIE: Thank you.

CHAIRMAN WATKINS: Dr. Lilly.

DR. LILLY: As far as I am concerned, you are preaching to the converted, of course.

I do have a few things to worry about here. AIDS is an enormous problem but it intersects with a number of other very enormous problems. Now, one of the other problems is drug abuse. Drug abuse is a phenomenally large problem and the two problems overlap very strongly. Interestingly enough, we have, in the Commission, taken a position very strongly about that particular problem. Yes, these two problems overlap. We are never going to get rid of either one of them unless we can do something about both of them.

Another major problem in this country that you have pointed out and which I couldn't agree with you more is the problem of homophobia. Homophobia and AIDS overlap enormously. I would be very happy if this Commission could come out with some statement to that effect.

That is my main comment. I have a second comment.

You mentioned early in your talk the line that we often hear, that AIDS is God's wrath rained on homosexuals. I have often taken to answering that by pointing out that, well, if that is true, God is using some mechanism and that with the help of scientists we found out what that mechanism is and we found ways to avoid it so that the homosexual community is going to suffer many more losses, but we will survive and we will have avoided God's wrath.

MR. WAHL: Well, Dr. Lilly, if AIDS were truly God's wrath against homosexuals, then God must favor lesbians because they are the group in society that is least at risk to AIDS.

CHAIRMAN WATKINS: Dr. Walsh.

DR. WALSH: Mr. Wahl, thank you for your statement.

I certainly feel that you are privileged to feel strongly about your position and that you ask for the tolerance and understanding of society, which you deserve. But I trust that you also would be equally tolerant of those who may disagree with you because that is one of the privileges of society.

So, some of those, and I am not one on the far right, believe me, but some of those on the far right believe as sincerely what they do, as you do what you do and that is part of what we are made of in this country and each of us has to live with the other without threatening the other.

The one thing I wish you had used in your testimony was the term "safer sex." I am one who believes there is no such thing as safe sex and I think that the Surgeon General regrets to this day that he ever used that term because this does mislead people into a sense of security. Safer sex, yes, I think that is fine; but never to preach that there is such a thing as totally safe sex because there just isn't.

A last question that I would have to you is what is your attitude towards an individual, whether he be heterosexual, bisexual or homosexual, who knows that he is seropositive and refuses to practice safer sex or refuses to modify his behavior?

Do you have any suggestions as to what actions society, if any, should take towards such an individual? It makes no difference where he comes from.

MR. WAHL: Starting with the last part of your question first, in our community, in the lesbian/gay/bisexual community, we have taken I suppose you could call them informal steps to identify such people and counsel them, find them and counsel them and tell them that that must stop. This is indicative of the responsibility we feel for our own lives.

Here in San Francisco, you know, we have quite a large proportion of gay, lesbian and bisexual people. We have added to the economy of San Francisco. We have added to the culture. We have added to every kind of activity, economic activity. I am a lawyer. We have doctors, we have plumbers, we have carpenters, we have people who have helped to build this city and are here to stay and we work well with people from the non-gay/lesbian/bisexual community.

We have a global village here that works. We realize our responsibility and we take steps to do that. We do not lobby for restrictive laws. We know how ineffective laws are in changing behavior. It takes a grass roots movement and that is what we have been doing.

Secondly, with regard to your statement about our rights to disagree, Dr. Walsh, you certainly have the right and I have the right and I am a strong defender of the First Amendment. The only case I argued in the Supreme Court of the United States was a First Amendment case. But I think that when we go beyond our right to disagree and we use what we are disagreeing about as something to repress each other -- if, for instance -- and I don't know what your stand is, Doctor, but if you took the position that if I were to test positive, that I should be put in some camp, that is going beyond our right to disagree. Or if you took the position that I should be taken to some clinic forcibly, if necessary, and have blood drawn to test it, that would be, I think, going beyond --

And I can't remember what your third point was, but --

DR. WALSH: No, I don't feel that way at all and I think you know that. My only point on that score is the responsibility -- it goes back to the question you didn't quite answer. I am very well aware of the efforts that the gay community has taken to, in effect, educate its own along the lines that you described. But we still have the problem. I say it is not a question of whether it is the gay community alone. I think it is as bad in the heterosexual community or the bisexual community, as to what do you do if the education that you give is simply not listened. Yes, they could be ostracized by you in your own community, perhaps, or something, but should this Commission be looking at something else, because as I say, you can't replicate San Francisco. Don't forget you are an unusual community here from the standpoint of education, foresight, vision.

We have been in many communities. This can't be replicated, regrettably. It just can't be because we have seen it tried and it just isn't -- and where you have the preponderance of new cases being among IV drug users and so on, for example, and our opportunity to provide them treatment centers or treatment on demand as we have recommended, you know, is not going to happen overnight. That is going to be a long process. I think we have recommended a ten year program, but somehow we have to get those who refuse to accept -- and I am not talking about sexual -- the normal human behavior of you should not be harming your fellow man intentionally.

What should we do? We would like to know this because you have been at it a far longer time that we have in education and in changing behavior patterns. What should we do as a society?

MR. WAHL: If you are asking what kind of a recommendation you should make -- pardon me?

DR. WALSH: In other words, to those who absolutely say "The hell with it, I am going to go out and do anything I please and I am not going to use protection," and it is not a question of whether he is a homosexual or anything else. What should society do?

MR. WAHL: I don't think that the Commission needs to make a recommendation for any new action because the tools exist, at least in California law. I am not admitted to any other bar except some federal bars in the Midwest, but I think that there is no need under California, and as I understand it, California law is fairly representative of public health laws throughout the nation -- I don't think there is any necessity for new legislation. I think it is very dangerous to recommend new legislation because there are people out there who want to take such recommendations and enact draconian measures, which are eventually going to fractionate society.

So, I think that you don't need to make recommendations in those areas because the laws exist. If somebody is really, really engaging in aggravated battery, that is a felony under California law. If that person is engaging in certain very dangerous conduct, threatening to the public health, there are statutes under California law that exist now and have existed probably since before I was born that allow the director of public health to take the necessary steps.

DR. WALSH: Does confidentiality, John, interfere with that? I mean, in other words under the law --

MR. WAHL: No, I don't think it does because if the public health -- the only -- you are getting at the question -- are you getting at the question, Doctor, do we need testing to find out who is doing this?

DR. WALSH: No, no, no, heavens no, heavens no. I am not getting at that. I am trying to find an answer for that very fractional few. It may be half of 1 percent but, nevertheless, it is a felony and it is assault with intention of bodily harm, certainly, as a possibility and if we are going to contain the disease, we don't have to worry about those of you in the homosexual community or those in the heterosexual community, who are seropositive but who will take normal precautions or essential precautions, but we have to worry about those who refuse to do it. And, you know, we have read about them in the paper; you have, too. They are a minority, but, nevertheless, they might as well be carrying a Saturday Night Special.

MR. WAHL: They are an extreme minority and they are such an anecdotal, you might say, minority, that the media immediately focuses on them, like the man that was the PBS -- PBS did a series --

DR. WALSH: Oh, that airline steward, yes.

MR. WAHL: I think that the public health officials when they find out about such a person and they have clear and convincing evidence that this person is threatening people, can take the appropriate steps without a lot of brouhaha. When the brouhaha occurs, that is when the people that want to change my people into nothing grab the standard and charge.

CHAIRMAN WATKINS: Dr. Crenshaw.

DR. CRENSHAW: You mentioned about the brouhaha and the press of exceptional cases and this needs me to a concern that I have that I would appreciate your comments on.

Could you discuss a little bit some of the split within the gay community of the differing points of view, as illustrated by Randy Shilts' book and a number of others, where there are those that are the most visible and get the most press attention, who, for example, in San Diego last month, 30 demonstrated against the closing of the bath houses, but I don't think that reflects the majority opinion today in the gay community but they don't get the visibility. And the visibility comes with those that are still holding to old party lines.

Now, in Randy's book there are comments that anyone who early on wanted to cut down on sexual partners and recommend exclusive relationships being accused of being monogamous, et cetera. If you could just comment on what your perception of the current division here in the gay community is and where the prevailing view is.

MR. WAHL: I would be glad to. I think it is very hard to say who is in the majority. We haven't had any public opinion polls, but, frankly, and I only speak for myself, it was a big mistake to close bath houses. Bath houses should have been used as educational facilities because it is very human to have sex. People are going to go out in other places where there aren't controlled environments, showers, the possibility of making them watch a 15 minute safe sex video before they get their towel and key. All of these things -- bath houses should definitely have been used as educational facilities and we would not have as many deaths as we have now if that had happened.

I think there is a tendency among some people in our community to blame the victim, to blame the victim. When you are in a oppressed minority and nobody can say that we are not an oppressed minority -- it was only about ten years ago that homosexual sex between males become non-felonious in California -- when you are in an oppressed minority, there is a tendency for some people to jump at the chance to agree with the oppressor or the majority.

I think you can find instances of this in all kinds of liberation movements, in all kinds of other minority liberation movements. There was -- and I am not calling anybody this, but there was the name "Uncle Tom" in the black liberation movement. I think that bath houses presented an opportunity, which is irrevocably lost in San Francisco, an opportunity to, as I say, make every patron watch a film, or you can have a lecturer there before he gets a towel and a key and perhaps get some nonoxynol-9 lubricant, get some condoms. This would probably -- not probably -- definitely have saved some lives.

The closing of the bath houses lost that opportunity. I don't think that people -- I want to add very quickly that people who advocate closing the bath houses in our community do not do so from bad motives. I think there was just a rush to find something fast that would take care of this problem because bath houses had always been something that some people in the majority did not like in San Francisco.

I think that people -- there was a legitimate disagreement between people who thought that monogamy should be advocated and people who thought that, no, you should just make sure that people used safe sex. I think that there is -- that the verdicts have not come in yet on all of these matters, but I don't think for a moment that you or any of the Commissioners should consider that people who opposed closing the bath houses are just promiscuous hedonists. They saw the closing of the bath houses as one attempt to use the epidemic to control the expression of our sexuality.

I personally saw the closing of the bath houses, as I have said, as a lost opportunity, a sadly lost opportunity to educate people and save lives.

DR. CRENSHAW: Are there any other areas where there is internal disagreement or active debate within the gay community on policy measures?

MR. WAHL: Yes. We are a very -- no pun intended -- heterogeneous community. We are just as diverse as you are diverse from Admiral Watkins or Dr. Lee. I mean, we are very, very different people.

DR. CRENSHAW: Could you be specific about a few more points?

MR. WAHL: With regard to AIDS?

DR. CRENSHAW: Yes, specifically.

MR. WAHL: Oh, gosh, I think if you want to get a kind of a tabulation of the kinds of points of few, I would refer you to Dr. Steve Morin of Congresswoman Pelosi's staff. I believe he is here in the audience today and I would also refer you to Mr. Larry Bush, aide to Mayor Agnos. He was aide to Mayor Agnos when he was an assemblyman and the author of most of the proactive AIDS legislation in California and models for proactive AIDS bills throughout the nation.

DR. CRENSHAW: I will leave it with the point that I think that there is -- from my impression, there is a lot of active debate within the gay community that doesn't necessarily filter down to the rest of us, so that it appears as though there is just one party line or one particular prevailing view, but I think that the discussion and the concern and the open disagreement is not divisive but productive as we search for the solutions that we are trying to find.

MR. WAHL: Oh, discussion is always productive, you know, and the last thing I would like to do is have my testimony be taken as an appeal to censorship. I just want my point of view heard.

CHAIRMAN WATKINS: Dr. SerVaas.

DR. SerVAAS: Thank you for coming.

I personally like all the gay men I know in Indiana, every one. I have never met one I didn't like. They are all responsible, bright, good civic-minded citizens and I think there are probably all kinds of gay men and probably most are responsible, but I saw the educational booklet that you talked about that Jesse Helms was able to get 92 Senators to -- Because of that booklet, I understand, he was able to get the bill passed that you abhor.

I wanted to tell you why I think that bill was passed. I think that when those Senators saw that book that they perceived it as being obscene. It was because of the exposed genitalia that they didn't like. Young men with very prominent genitalia -- they didn't like the obscenity of it not -- so, I just believe that that is where that Gay Men's Health Crisis in New York, whatever organization it was that put out that book -- and I didn't know what you might have to say about that or have you seen the book? That is one question that I have for you. Did you see the book, the booklet that he used?

And then the other thing that I want to know is not all gay men would have banded together and really worked at preventing gay blood from being deferred when we knew about the hemophiliac cases and the blood transfusion cases, but there were some who did and I think that if you had a little better control over those who don't have the good of all in mind as much as to have worked as they did at that time to prevent deferring gay blood because it would stigmatize the gays at the blood banks -- now, that group surely doesn't represent our Indiana gay men because I don't think they would do that and I just want you to tell me what you think about those two things, the obscene literature that was being put out by a group of gays and I don't think ACT-UP represents the gays of this country.

I think there are a lot of very wonderful men who happen to be gay, but I don't think ACT-UP is representative. Now, how can you control your fringe elements so that we all work together for the good of all, the common goal?

MR. WAHL: Well, Dr. SerVaas, responding to your first question first, with regard to the safe sex booklets that apparently Jesse Helms waved on the Senate floor, I have seen those booklets and obscenity, like beauty, is in the eye of the beholder, most respectfully, Doctor. You know, there was a movement some years ago, about ten years ago, by some people to put clothes on animals and people really thought -- there were some people who thought that this should be done. They thought this should be an advance in society because they thought the exposition of genitalia was somehow obscene.

I do not consider an erect penis to be something obscene. I think that it is something that is natural. It is in the course of creation. I think that the way one -- it does get kind of into a comedy line almost here, but the way one uses an erect penis, either pictorially or if it is your own or some -- it can be either good or bad, depending on a lot of factors.

I don't think sex that is violent or forceful or is done through drugs or some kind of deception is moral. I think that consensual sex between two people is nobody else's business. It certainly isn't my business. It isn't Jesse Helms' business. I think that people are going to continue to have sex no matter what -- a hundred years after you and I and Jesse Helms and Admiral Watkins are long forgotten and the fact is --

DR. LEE: Not Admiral Watkins, no. He won't --

[Laughter.]

MR. WAHL: Maybe not Admiral Watkins, but the fact is that we have an opportunity to reach a group of threatened people and if the book has a bunch of erect penises on it, you know, that is just what is necessary to reach some people. I don't know whether it is or not, but I think it definitely will reach people that other books won't.

I am a guest lecturer at the Institute for the Advanced Study of Human Sexuality here in San Francisco, which is an accredited, degree-granting, Ph.D.-granting educational institution. I think Dr. Crenshaw may be aware of it. I am not sure, but at any rate, this organization has the largest library in the area of sexual materials I think anywhere in the world, and they have a great capability to produce safe sex materials. They have produced videos and books and I believe Dr. McIlvenna, the President, is sending you copies, which some of you may find obscene. The fact is they offered them to the Center for Disease Control because these books, these videos, these materials could save lives. The Center for Disease Control returned them unopened. They said we just don't get into this material.

I think that we have to -- and most respectfully, I think we have to look at the priorities in our nation. The priority I see is to save lives. Jesse Helms got 92 Senators to react very quickly -- I understand that some of those Senators now wish they had not voted that way, but they didn't have a chance. They were faced with people waving something that people haven't historically waved around on the floor of the Senate.

Now, is it better to save my life or not to let that booklet be printed? Which is better?

DR. SerVAAS: Well, okay. Move on to the -- how do you control the groups who would have -- you were talking about saving lives.

MR. WAHL: Yes.

DR. SerVAAS: Would have saved lives had we not had that vociferous reaction. Now, how do you respond to that? That isn't all the gay men. That is a small group. Is that right?

MR. WAHL: I am a past National Steering Committee member of Mobilization Against AIDS, which long ago took the position that the blood supply should be tested. If somebody is going to volunteer to donate blood, they should be tested. That is just a public health measure. That is a very voluntary thing, to donate blood. So, I think that we should have done that -- the nation -- I say "we" as the nation should have done that early on. We certainly do it now and to the extent that the HIV antibody test is accurate and I suppose when the newer tests come down the line, we can absolutely filter out bad blood.

DR. SerVAAS: Then you weren't part of the group that didn't want gay blood to be deferred? You wanted to be able to donate in the early days?

MR. WAHL: I think that I should be allowed to give blood if I am negative. The fact that I am gay has nothing to do with the viability of my blood. I don't think that that should be something that should be used at all, the sexual orientation criteria.

The fact of whether or not somebody has an antibody that shows that they have a dangerous virus should be used. I think heterosexuals who have the antibody should not give blood. I think heterosexuals who have hepatitis, any kind of hepatitis should not give blood.

DR. SerVAAS: Mr. Wahl, I was referring to before we had a test and the only protection they had for the hemophiliacs, for example, was deferring blood in high risk groups and there was a lot of resentment about that.

I wondered if that is a small group of gay men or is that the policy of your organization are you that well-organized? Is it all the gay men who felt that way?

MR. WAHL: Well, Dr. SerVaas, we are certainly not monolithic, gay men, lesbians or bisexuals, just as Christians are not monolithic, Jews are not, et cetera. I think that -- and I couldn't really tell you back in those days how many people would take one position or another. I know that it is -- I don't think there is any opposition in the gay, lesbian or bisexual community to testing blood or testing donors for the presence of the antibody or the antigen when it comes down.

DR. SerVAAS: Okay. Thank you.

CHAIRMAN WATKINS: To close out the panel, Mr. Wahl, just let me ask you one question within your testimony.

Could you describe some of the AIDS-related activities of the church groups with which you have been involved in a little more detail? Who made up those church groups, who are they, is there certain elements of leadership there? Are there any recommendations you can make to the Commission church group involvement in such things as educating from the pulpit, educating their own, helping out in binding up some of the wounds that you have been talking about?

We have indication that some church groups, in fact, are aiding and abetting some of the fear that you talked about earlier. So, is there something there that you have worked with where you could give us the benefit of your experience and perhaps some recommendations?

MR. WAHL: Yes, Admiral. In San Francisco, the San Francisco Night Ministry is about -- I think it is 17 or 18 years old now or maybe it is over 20. It is a project of the Council of Churches, but it is a non-judgmental ministry that is on the streets of San Francisco every night when all the social agencies are closed, between 10:00 p.m. and 4:00 a.m. We have some crisis counseling. We have volunteers that sit at a phone during those hours and can page the night minister, who rarely gets into religious discussions with the people he talks to.

We have some food capability. We also have some very limited emergency housing capability for a few times we find somebody with children.

Anyway, the night minister is more and more dealing with people who -- and this is just a small part of what I am going to talk about, but he more and more deals with people who are abandoned on the street or feel abandoned by all the social agencies. Maybe they are in a group that is -- or maybe the person is a poverty-stricken young man, who has come to San Francisco and who gets sick before he can get a job and finds that he has AIDS and can't handle going through the bureaucratic maze and is wandering around the streets and meets the night minister. The night minister then knows how to channel him the next day into some kind of appropriate assisting system.

The San Francisco Council of Churches has a Social Justice Commission. I happen to be chair of it. One of the people on it is Reverend James Sandmire, who also happens to be a police chaplain in San Francisco. He is a gay man. He is pastor of Golden Gate Metropolitan Community Church. He has been working with ministers in -- he also has AIDS, but he functions very well as pastor of the church. He has been since his diagnosis and we hope he will continue to do so. He has prepared a modus operandi -- I don't know what the word is, some kind of an operating system as a guide for ministers and for people in the church to deal with people with AIDS and with the whole question of AIDS in a non-judgmental, helping way.

We have been working on it for some time. We have been actually working in accordance with those guidelines for some time, but the guidelines have not yet been formally approved, although people have been using them for some time.

In San Francisco we have a range of churches that is just as varied as it is anywhere else. We have one church in San Francisco that fired an organist several years ago because the organist was gay and that pastor refuses to join the Council of Churches.

We also have a number of churches that are very proactive, who want to see that gay men and lesbians and bisexual people have just as full and rewarding and non-hassled life as anybody else. Those people, I think, reflect the thinking of most of the people on the Council of Churches.

We also have people on the Council of Churches, who believe that homosexuality is sinful and I sit at board meetings with them, but I think that they also believe that it isn't their business to interfere in the way that I or any other gay man or lesbian or bisexual is treated by the state, by the government, by society, that we should all be equally treated.

It is a stumbling block, of course, to complete cooperation, this divergence of views on the theology of same sex orientation. I think in San Francisco we are not running from that issue. We are facing it. The Social Justice Commission will be working on study papers about different points of view on this issue, which might be seminal papers, might be of some value to the rest of the nation. I don't know.

CHAIRMAN WATKINS: Okay. Thank you very much, Mr. Wahl, for coming before the Commission today and we have got to move on now to our first panel of the afternoon and our only panel today. We are scheduled to adjourn promptly at 3:30, so that we can proceed with our scheduled site visit with the Shanti Project.

Our first panel this afternoon is the panel on corporate response to AIDS, which consists of Mr. Robert N. Beck, Executive Vice President, Bank of American, San Francisco; Dr. Bryan Lawton, Vice President, Employee Assistance Services, Wells Fargo Bank, San Francisco; Cynthia D'Anna, Employee Assistance Counselor, Pacific Gas and Electric here in San Francisco; Fred Brundage, Director of Membership, San Francisco Chamber of Commerce; and Carolyn Wean, Vice President and General Manager, KPIX-TV, San Francisco. We would like you to come up and take your places at the panel, please.

We have received your formal statements in some cases, I think maybe perhaps in all cases, and would like to try to stay with the protocol of five to not more than ten minutes, preferably around five minutes. We have your papers. They are a matter of official record. You do not have to read them. If you can summarize them to stay within the time frame, we would be very appreciative, so we can get on to the dialogue of questions and answers from the Commissioners. This is where we can glean the most knowledge and we can read about the wonders of your activities, but what we really want are your recommendations of what this Commission can do to help guide the country.

So, with that, we will start with Mr. Robert Beck first today. You will have to pass that microphone back and forth.

MR. BECK: Thank you, Admiral Watkins and other Members of the Commission. Our first experience with AIDS was one of the first in the Bay Area. It was back in 1983 and it came about with an employee who thought he had a different kind of illness or disease and when it was first diagnosed as AIDS, he then asked to come back to work.

I have to take you back to the 1983 time frame because at that point in time, it was a tremendously different environment than it is now. The media was showing a considerable bit of mass hysteria starting to go on with people wearing rubber gloves and masks and that sort of thing. So, it was of concern to us because we didn't know what was happening as far as this.

We did call on CDC in Atlanta. We called on our colleagues at the University of California-San Francisco and we concluded that it was right to bring this person back to work. We assembled a group of people together, benefits people, legal people, employee relations people and decided that we would not treat AIDS in a different way, that it was a life-threatening illness and how would we treat life-threatening illnesses? I think it was a very fundamental policy decision for us and I can tell you that it served us well because instead of singling out AIDS education or AIDS programs, we put it right into the mainstream of our business in the fact that we do other health awareness type programs, whether it hypertension or exercise or other types of health programs.

So, we tried to make it as part of the regular communications with our employers and our managers. That was particularly important in light of this semi-hysteria that was going on and the tremendous fear in the public that was building. We did, in fact, have some problems in the very beginning because we had some employees fearful to work with an employee with AIDS, but we finally concluded that it was the right thing to do.

Once we made that policy decision that this was a life-threatening illness and we would treat it that way, we then decided how should we communicate this. And we concluded on another basis that we hadn't done this with any other illnesses and diseases in a massive way, such as make mandatory department meetings of all our employees in California or the nation, which is about 59,000 employees. We concluded that would be the wrong thing to do, but do it on a what I would call a case-by-case basis from a mandatory standpoint, but that didn't mean that we didn't want to communicate our policy. It was important and particularly as '84 and '85 and '86 rolled around and the number of cases grew, we felt that all of our managers had to know and our managers knew where to get the information.

We also knew that our company responsibility was to educate our people in a general way, not at department meetings, so we ran articles in our employee newsletter. We worked with the San Francisco AIDS Foundation and other people in the community, as well as other businesses and produced a video tape. I think we were one of the first groups to do that in the City of San Francisco and all the employers used that. That served us well.

So, when an employee would want to return to work, then what would typically happen is the employee would come forward and disclose their situation; particularly important in California because the privacy laws in California are extremely tough as far as confidentiality on any matter and particularly on a health matter. So, we didn't want to wind up having a lawsuit because someone disclosed a personal illness of an individual.

I would tell you that in every case the employees would inform the manager and the manager would then inform the colleagues that he is working with that he has AIDS. The manager then turns to the employee relations people and we usually have a staff meeting and explain that there is harm in the workplace and so on. You know all of those kind of things.

Another significant thing we did, I believe, was look at health care costs. Some of our early AIDS patients didn't know what was happening and the medical community didn't know how to deal with it and they put these people in intensive care wards. We happen to have a co-payment in our medical plan, including hospitalization, and some of these employees at that price per day were running up pretty big bills with out-of-pocket costs. Some even started borrowing money from colleagues, thinking from a compassion standpoint this person would get better.

That turned out to be an employee relations concern and we quickly got into the idea of getting involved into managed care and working again with the community providers. We put heavy emphasis on use of hospice and the Shanti Project and some of those types of organizations. We encouraged our employees to come forward and talk about alternative care and how to deal with alternative on a cost effective basis.

That has served us well and to give you some numbers, for example, the AIDS patients in San Francisco are running about 20 to 30 thousand dollars per case versus the reports we hear is anywhere from 50 to 60 thousand to over a hundred thousand dollars in other major cities in the United States.

At the Bank of America, since we got an early start on this, our patients have averaged -- in 1986, were $17,000.00 and that cost has now risen to $25,000.00, and mainly because of the introduction of the drug AZT and the cost that that yields. But, still, $25,000.00 is significantly less than what we are seeing nationwide.

So, this idea of getting involved and helping these people understand what the appropriate medical care is is serving them well and serving us well.

I guess the key thing that we concluded out of all this is that, first, working together is important -- it takes partnership. Fifteen major companies banded together, Levi-Strauss, Pacific Telephone and so on, to share our resources, and work with the providers, such as University of California, CDC, San Francisco AIDS Foundation and others. Working together jointly, we found out we had synergism instead of duplicating our resources. That was a very powerful thing.

And then, secondly, the communications of this to our employees was critical. In fact, people come forward now and do testimonies in our employee newsletter or on the videos, because they feel we are a compassionate employer and we care. We have created an environment where, in fact, the employees, instead of reacting generally with fear, are now acting with compassion.

We actually wound up having to move to a third phase and that is the grief process. We have had to train our personnel relations people on how to help the current work force deal with the fact that they know this AIDS employee is going to die and, in fact, they do die and do they help the department overcome the grief process that is there.

So, we have gone through all phases. Our policy has served us well and our employees have a very positive reaction. The last piece is that we accepted a responsibility to communicate not only to our employees, but since we were one of the first companies in America to get out in front on this, we have been available to the media. As a result, we have been on almost every major media in the United States, Fortune, Business Week and so on. We have been on Good Morning, America, Ted Koppel's Nightline and probably communicated with 750 different companies our policies and shared it with them. I think that is part of the price you pay to help solve this national problem. That is good community citizenship and our management team supports that. Thank you.

CHAIRMAN WATKINS: Thank you, Mr. Beck. Dr. Lawton.

DR. LAWTON: Thank you, Admiral Watkins. I am pleased to be able to present Wells Fargo response to AIDS.

Concern about AIDS was first addressed by Wells Fargo, which, I believe, was the first company in the Bay Area to address the epidemic, back in May of 1983, when we had an employee with AIDS who asked to return to work and who had a doctor's permission to do so.

Our Employee Assistance Services (EAS) Department was asked to research the medical aspects of this disease and to make recommendations to management on the employee's request to return to work. After consultation with both the San Francisco Health Department, the Centers for Disease Control, as well as other community and medical experts on AIDS, the Employee Assistance Department was asked to develop a medically-approved AIDS policy in order to address the personnel reporting issues and management procedures on AIDS and develop and implement an AIDS education program to reduce the fear that had developed at that point regarding the casual spread of this disease.

It was decided that the stated AIDS policy, the company's commitment, would first try to protect all employees' health and well-being. It also explained the necessity for providing accurate medical information on AIDS, identifying the risk factors for contracting the disease and encouraging individuals to take necessary steps to prevent contracting this disease in the future.

The policy emphasized the company interest as well in minimizing work disruption problems and morale problems of healthy employees asked to work with AIDS-infected employees. Additionally, it expressed the company's commitment to provide reasonable accommodation for an employee with AIDS who was medically fit to work.

Finally, supervisors were instructed to treat AIDS-infected employees with sensitivity, compassion and understanding and to treat AIDS information as confidential. We decided to go forward with a specific AIDS policy at that point because we wanted to ensure both uniformity and consistency in the application of our policy procedures.

Perhaps the most notable result of our education program has been that over five years now we have been able to successfully return our AIDS-infected employees to work without any problem. There has been no work disruption experience with any employee's return nor any significant work-related problems related to the employee's illness. The positive results of our educational efforts have been, perhaps, most noted by the fact that our employees feel good about working for a company that cares about them and their health, as well as is trying to ensure that they have the necessary information to educate their families.

After this initial educational program, we then began to identify geographical areas where higher concentration of AIDS cases were being diagnosed for future educational efforts. Personnel representatives and later managers throughout the company were provided both the company policy and procedures, as well as given a general medical overview of the disease and allowed for a question and answer period.

We also wanted to make sure that our employees had their questions addressed and so we then began developing educational programming across all those various departments with an outside medical expert to assist us.

Since the development of our AIDS policy, which has been both provided in our employee and supervisor's handbook, the company has also had an ongoing educational effort in terms of providing information on AIDS to all employees. Some of those things that we have done would include, for instance, distributing Surgeon General Koop's brochure to all employees, as well as distributing, through the health column in our company newspaper, four different articles on AIDS.

We currently are providing AIDS education to all departments, upon request, as well as a part of our overall health promotion efforts. When education is provided to a department anticipating the return of an employee diagnosed with AIDS or ARC or other HIV condition, we suggest making the presentation to the entire work division, rather than to that specific group, both to protect their anonymity, as well as to ensure that the confidentiality of that employee is protected.

Providing AIDS education, we think, has demonstrated that it both employees' fears, as well as prevents any work disruption problems from occurring. It is basically what doesn't happen that is important when you have a good educational program.

We currently are using the AIDS education program that was developed by the San Francisco Business Leaders Task Force, as well as the San Francisco AIDS Foundation, <u>AIDS: An Epidemic of Fear</u>, and we are now using the recent update, which just came out in the beginning of this year. This information, as you know, reflects the best medical information from both the Departments of Health, as well as the Centers for Disease Control, and one that really conveys to employees that AIDS is not spread from casual contact.

We also have been providing, as a part of our education effort, information to employees in terms of other brochures, a two-page memo that describes our policy, as well as reassuring them that we keep our medical policy both legally and medically updated. Following the education, employees are requested to complete a confidential evaluation form, which has shown over time that we have been able to demonstrate significant positive change, both in terms of employee attitudes, fear and knowledge about AIDS and it not being spread through casual contact.

Our educational programs can take, when we bring in an outside speaker, using the video, between one to one and a half hours maximum and that allows for both a medical question and answer period in addition to the video. We also when we do it occasionally will not have a speaker and that will take roughly 30 to 40 minutes.

We have also had to provide education to employees about the confusion that has existed around the possibility of AIDS being transmitted through giving blood. Many people still falsely believe that that is the case and we have been trying to reassure our employees to hopefully be able to give blood in comfort and safety.

Like Bank of America, we also have found the benefit of both providing medical case management, as well as health care benefits that would allow for both hospice care, as well as home health care. We think that this can benefit both AIDS cases, as well as any other major medical problem.

Additionally, all aspects of our company operation have been examined from a safety perspective to make sure that there are no operational practices that need to be changed. For instance, in the provision of CPR in an emergency situation, we now train everyone to assess their own personal consequences of providing CPR intervention, as well as provide special mouthpieces to eliminate the need for mouth-to-mouth contact.

Our Foundation has made a number of financial contributions, both on a local and national level since 1983, which has totaled over $165,000.00, as relates to AIDS-related concerns.

I must say that one of the things that we have found is that only one employee in the last five years has made any challenge or question as to our policy, which was back in 1983, and that challenge was able to be resolved successfully internally through consultation with employee assistance and employee relations and then referral to outside medical community experts, which basically put that person at ease.

Wells Fargo currently is represented on the board and was a founding member of the National Leadership Coalition on AIDS, in which I represent our company, and this is the private sector vehicle for mounting a coordinated effort between the public and private sector. I really believe that this is a very critical tool that perhaps the President's Commission might want to focus on in terms of trying to ensure a better collaboration between the Centers for Disease Control, as well as the public and private sector efforts.

We also participated and led the Human Resource Task Force in the Allstate-sponsored forum on public issues, AIDS: Corporate America Responds, and we strongly endorse the recommendations in that report, as well as have participated in numerous public and private sector forums on AIDS, based upon our experience, as well as policy and procedures.

Overall, in light of the heavy publicity and sometimes hysteria that media attention has brought by focusing on this issue, as well as the potential for work disruption and employee morale problems, with the extraordinary health cost of AIDS and the possibility for discrimination suits, every company, I think, now must consider developing a policy, as well as an educational program to help their employees to overcome their fear about this disease and, hopefully have both compassion and sensitive understanding when someone, perhaps, they know develops this disease.

In terms of specific recommendations that might help the committee, looking at it from a broader perspective, beyond our company, but looking at corporate America at large, some recommendations I would like to make would include the following:

Hopefully, the White House might, at this point, be able to show increased leadership to encourage every American to personally understand how AIDS is spread, encourage them to take preventative efforts and be compassionate and understanding about anyone who may so be affected.

Secondly, I think there needs to be, perhaps, a reexamination about the money that is being committed in 1989 in terms of the levels of funding for AIDS-related activities. It has been suggested by the National Academy of Sciences that there needs to be an increase of approximately $700,000.00 to 2.1 billion, so that we have an increased emphasis on both preventative efforts, as well as educational efforts. In specific, I think that there needs to be more efforts to provide education for the minority groups, who may be most affected by this disease.

Government leadership, I think, can also help in terms of providing either funding or grants to ensure health care planning at both the state and national level, to hopefully forge an increased collaborative effort between the public and private sector by calling, perhaps, on the top people in corporate America around the country to develop, along with the public sector, a cohesive local, state and national strategy.

Additionally, government I think must encourage non-discrimination in the work place by the private sector through legislation, if necessary, and should develop a government interface department to aid employers in resource-sharing and dissemination of education to employees and family members.

Additionally, government should avoid, I think, supporting mandatory testing as an unnecessary waste of needed resources unless recommended by the public health services and the Centers for Disease Control.

Government also, I think, needs to provide increased funding for the treatment of IV drug abuse to avoid the lengthy delays in treatment.

Additionally, government must provide more explicit messages on AIDS to all Americans through mailings at every home, as the CDC has proposed and I understand is still waiting to deliver on.

Additionally, I think government needs to help educate Americans on the safety of the food industry products from AIDS contamination. I think that this industry faces some very unique problems in terms of trying to reassure the general American public that the food industry is not in danger if, in fact, they employ people who may have AIDS.

I think the government must also prohibit AIDS discrimination in health insurance coverage. Government should support, I think, the development of either cost-sharing between the insurance industry employer and the Federal Government through risk pooling or stop loss programs. This is especially critical for the smaller employer, where providing health coverage is becoming increasingly prohibitive due to the additional cost of AIDS and the difficulty in getting insurance coverage.

I think government should also provide or consider providing increased funding to states where there is a higher prevalence of AIDS cases.

Additionally, government should consider changing the reimbursement to accelerate the qualifications for medical assistance in social security benefits in AIDS cases.

Finally, hopefully, the government should provide more funding for counseling services related to HIV testing, family clinics and sexually transmitted disease clinics. Hopefully, through this sort of increased funding effort and preventative and educational effort, both the public and private sector can share our resources and efforts in stopping the spread of this disease. Thank you very much.

CHAIRMAN WATKINS: Thank you very much, Dr. Lawton. Ms. D'Anna.

MS. D'ANNA: Thank you, Admiral Watkins.

I would like to give you an overview of PG&E's response to the AIDS epidemic and would like to commend you for your interest in the corporate response. There can be no doubt that Acquired Immune Deficiency Syndrome is one of the most serious health problems of our time.

Let me give you a brief description of our company. We have approximately 29,000 employees throughout northern California, with a corporate center in San Francisco and with employees situated in small towns in the Sierra Nevada, Needles, and other rural areas. So, the number of employees ranges in terms of the population types. The types of jobs range from management, clerical, technical and physical.

The Employee Assistance Program is a confidential and voluntary mental health benefit to employees and their families. The program provides assistance for a broad range of personal problems, including family, marital, psychological, drug, and alcohol. We consult with management and supervisors when a mental health perspective is needed.

The Employee Assistance Program provides prevention and educational programs, including AIDS education. Several PG&E employees have contracted or died of AIDS. As with any untimely death of any employee, the company recognizes the sense of loss that this tragedy brings to family and friends and co-workers.

PG&E supervisors are expected to approach this issue as it relates to the company work setting, with accurate information and not with unjustified reactions based on fear or ignorance.

Medical and educational experts agree and it has been our experience that education is the key to stopping both the spread of the disease itself and minimizing the natural fear that often accompanies this disease.

The company's position on AIDS reflects the stance of the United States Department of Health and Human Services, that employees with AIDS do not present a health risk to other employees in the work place. PG&E tackles this problem with a strategy that consists of four key elements, and they are: knowing the company's concerns, communicating the company's position to the employees, providing ongoing educational and counseling services to employees, and keeping current with updated information on a regular basis.

In terms of knowing the company's concerns, I would like to provide you with a historical perspective. The company first became aware of the crisis in 1983, when several service employees were concerned about going into the homes of some customers. Many employees at the time were afraid that AIDS could be transmitted through casual contact. Not only was there unjustified fear towards employees with AIDS but anyone who was thought to be a "high risk" group became suspect.

The first step in addressing these concerns was to contract with Dr. Paul Volberding, national AIDS health expert. A general meeting was conducted in October of '83 and employees were able to ask questions. This presentation was video taped and sent to all employees systemwide. The approach served to be extremely successful in reducing fears and changing some misconceptions of how the disease was transmitted, but most importantly, the employees felt that their concerns were addressed and for the most part for that particular group, the issue became a non-issue.

The company communicates its position to employees through its AIDS policy. PG&E was one of the first companies to develop a policy on AIDS. The basic premise is that an employee with AIDS does not present a health risk to other employees with AIDS.

AIDS is also treated like any other life-threatening or chronic illness, in that the same benefits and the same programs within the company are available. The company prohibits discrimination of individuals who have AIDS, and employees have a right for their confidentiality to be maintained if they wish that.

If, and only if, there is a question of fitness for duty can a medical evaluation occur and that is the same as any other type of fitness-for-duty issue.

The third and most extensive portion of our program is the counseling and educational services to employees. The Employee Assistance Program has the responsibility to provide these services. Our counselors are trained to assist the employee, their manager and supervisor, their co-workers and family members in addressing and understanding the disease.

We provide emotional support, working both with individuals and with the group. We make referrals for psychological and medical assistance, and when it is finally necessary, we assist in the grieving process for both the individual families and the work groups.

The counselors also consult with supervisors or managers on issues pertaining to the work group, staffing needs, medical leave or conditional return to work. Employees are encouraged to remain on the job until they no longer can or want to work.

The Employee Assistance role is that of managing the cases, providing doctor's recommendations to the supervisors, and giving support to the employee and protecting confidentiality if the employee so desires.

The educational and informational presentations are given to work groups and management. These presentations change their focus based on the needs. Initially, issues regarding casual contact were addressed. The focus has moved to prevention and low-risk behavior. Currently, the needs have shifted to supporting people through the grieving process.

This movement occurred based on the fact that until there is a cure or a vaccine, prevention and engaging in low-risk behavior is the most effective way of curtailing the spread of AIDS at this time.

Our Employee Assistance counselors are situated geographically throughout the state. So, the needs are quite different in the metropolitan area of San Francisco versus Needles, California. So, the programs are developed based on the needs of each group.

We have a commitment to keep current. Dr. Paul Volberding continues to be on contract with the company. He has made two video taped noontime presentations, providing information on the most recent medical conference on AIDS.

Additionally, topics have included the impact on the family and alternative home hospice care treatment. Also, one that was completed just last week was, "How to Talk to Your Kids About AIDS." PG&E takes this kind of responsibility because they can't afford not to. Current projections indicate that by 1992, there will be 270,000 people in the United States that will have AIDS. Based on these projections, PG&E estimates that there will be 175 employees who develop AIDS during the same time period, and those figures are based on low estimates.

In 1997, the company predicts 455 cases. Health care costs can skyrocket and insurance costs are likely to soar. Experts also agree that the most effective way to curtail this cost is through prevention and education. Other recommendations have to do with providing funding through insurance companies for home hospice care and less expensive alternative treatment for individuals with AIDS.

In my two years with PG&E in the Employee Assistance Program, I have seen new trends emerging. The most significant to me are the concerns of the clients who actually contact the program. Initially, people would call, afraid to work around employees with AIDS and panicked because they were worried about their safety.

Last week I saw an individual who I think represents a major shift in the concerns of our employees at PG&E. A woman came in very distressed because someone she had worked next to for 15 years had recently been diagnosed with AIDS. She wanted to know how to work through her own feelings of grief and loss, while trying to understand what her co-worker was going through and offering support.

This speaks both to the effectiveness of the education and to the emotional and psychological process that accompanies any fatal disease that is transforming fear and misunderstanding to caring and acceptance.

The company is seen as a model and networks with other corporations, both in the area and throughout the country. We work closely with local resources, plus the Business Task Force here. We are also members of national professional organizations, to which we provide information, such as the Association for Labor Management Administration and Consultants on Alcoholism (ALMACA), and the Edison Electric Institute.

It has been a pleasure to share with you the Pacific Gas and Electric Company's experience in dealing with the issue of AIDS.

CHAIRMAN WATKINS: Thank you very much, Ms.D'Anna. Mr. Brundage?

MR.BRUNDAGE: Thank you very much. Thank you especially for the invitation to attend the hearings today. My remarks will be rather brief.

The San Francisco Chamber of Commerce is a private, non-profit membership organization. We rely strictly on members' investments. We receive no tax money. There is no foundation money or grants of any type. We have over 3,000 members in the organization. They range from individuals on up to the major corporations in the Bay Area.

The Chamber's involvement in the AIDS crisis actually took active form approximately a year ago with the publishing of our Aid in the Workplace Guidelines and simultaneously the formation of the Executive Leadership Council on AIDS in San Francisco.

AIDS in the Workplace Guidelines were authored by Dr. Julius Krevens, who is the Chancellor of University of California at San Francisco and also a board member of the Chamber.

The Chamber is the first known business organization to organize a nationwide AIDS in the workplace policy. The Executive Leadership Council on AIDS in San Francisco is a working group that is comprised of the California Business Roundtable, which is the largest corporations in California, the United Way of the Bay Area, the Chamber and several of the local major corporations in this area.

The first project of this council was to expand the number of California corporations offering AIDS education and information to their employees. Their first publication will be due out in about two weeks.

The Chamber in cooperation with the San Francisco AIDS Foundation mailed to all 3,000 of our members a very informative booklet that was generously underwritten by the Pacific Mutual Life Insurance Company, that deals with facilitating AIDS education in the workplace.

In the fall of last year, as part of a membership survey, we asked our members how involved we should become with the AIDS crisis and over 50 percent of the respondents said that the Chamber should -- disseminating AIDS information should be a major activity of our Chamber of Commerce. We received many more requests than we could possibly accommodate. We do co-sponsor different functions in the city and in the Bay Area and the message that I would leave today since our Chamber is similar to most of the Chambers across this country in the fact that 80 percent of all the members are small business people and the small business people are the people that are not getting much of the message.

The larger corporations in house can do marvelous things and are doing marvelous things and their organizations are doing wondrous work, but it is the small business person that really needs, at this point anyway, to get the message.

I think that the Chambers of Commerce across the country are a perfect clearinghouse, a perfect channel for this type of dissemination of information. Thank you.

DR. WALSH: Thank you. All right. Ms. -- how do you pronounce that, Wean, Wayne?

MS. WEAN: Wean. The opposite of mean.

[Laughter.]

DR. WALSH: All right. We will have Ms. Mean Wean.

[Laughter.]

MS. WEAN: Ms. Mean Wean, yes.

[Laughter.]

As a television station we have a two-fold mission; one is to inform our public about AIDS and the other is, of course, to inform ourselves. The theme -- probably by the time that I have finished, you may be a little bit tired of hearing it -- but the theme of both those missions has been that it is only through the cooperation of community organizations, our own business, television, and the cooperation of other businesses in the Bay Area that we have been able to fulfill those two missions.

We have had sponsorship for the programs that we have created. We have been able to use the San Francisco AIDS Foundation, their people and their expertise to come in and help educate all of us who work at KPIX. And their efforts, in turn, have been underwritten by the business community in San Francisco. So, it is a full circle of our information to the public being support by the community and our information to ourselves being supported by the community and other businesses in the Bay Area.

I would like to first talk a little about the efforts to inform the public. For quite some time, over four years, KPIX has been instrumental in getting out information to the public at large and rather than me describe that, I would like to play a brief video tape that certainly captures, I think, the variety of the kinds of programs and messages we have been able to put out, again, only with the help of experts in the field, community organizations working in AIDS and the support of sponsorship.

[The video tape was presented at this time.]

Obviously, I am very proud of that tape, not just because it represents KPIX but because it represents all of those examples of individuals and organizations and businesses that have stepped forward to, in whatever way they could, deal with the situation and be of help to individuals.

Another situation that I am particularly proud of, and really this was created more by informal information -- we are a little later than some of the people at the table to the formal process of informing our own, but because there was so much informal information at large in the station, unlike some other television stations in the country, we have never had a refusal to work on a studio program where there were many people who suffered from AIDS, nor have we ever had a refusal by anyone to go into a hospital or to a home where they would have to photograph, interview, talk with people who had AIDS or with people who were engaged in the care of AIDS.

But, nonetheless, after a thousand news stories, we did sit back and say are we well enough informed; you know, we have put out all these stories. Have we really taken care of the situation here at the station? And we found that, of course, we did have some unanswered questions, some fears, some concerns and we wondered what we would do, even though we had very formal policies, what we would do as managers if we were confronted with one of us having AIDS or if one of the employees had AIDS.

With some help of experts, again from the San Francisco AIDS Foundation, again supported by the business community, we set up a series of seminars, seminars first directed to all of us, where we could talk with people who were engaged in AIDS care and very knowledgeable, hear what they had to say and ask the personal individual question that still may not have been answered, even after a thousand news reports.

Those were very valuable. People learned a lot and I will share with you my own personal story. I, of course, went to show support because after all as the general manager, who had viewed many of these reports, talked with reporters, discussed the scripts, I certainly was well-informed. And the woman who led our discussion started out with a brief quiz, if you will, of true/false questions, which we answered. We then went through the discussion and then we re-answered them. And I, like many other people in that room, found that I didn't know all the answers. So, no matter how much as a lay person you are informed, there are still specific questions, some of them small, but, nonetheless very important to you that need to be answered. And I think that can only be done in small groups, and the work place is one arena, where you have the support of the people around you and asking sometimes what seems to be a stupid or fearful question that you may be afraid to bring out in another situation.

Those seminars were a great success. We also then followed up with a series of workshops, seminars, meetings with managers and other employees, to make sure that we understood what our policies were should somebody become an AIDS patient. Simply put, our policy is the same for anyone who suffers from AIDS that would suffer from any debilitating or chronic disease.

Insurance benefits would be the same. The disability benefits would be the same. Confidentiality would be the same. The same counseling programs would be available, of course, specifically addressed to the specific needs of people who suffer from AIDS.

We are certainly hopeful that given the experience that we have had with the many people who have had to cover stories and work on programs in the studio, that the population of the station at large would accept and not be overly-concerned about an employee, if one should come down with AIDS.

Our general thoughts and policy about someone who would have AIDS is that as long as they are able to perform their job, just as anyone else, they will be able to work and that we cannot refuse to work with people who have AIDS. So, it was again the community partnership that helped us to address our own specific needs.

The video tape that you saw, as many of you know, has been distributed across the country, the elements in that video tape, so that other stations could take advantage of what we have done here.

In addition to our own efforts inside the station, I would like to give just a few more examples of public/private partnerships that have helped to educate the public and helped to educate us as individuals.

In 1985, the San Francisco AIDS Foundation and KPIX created a brochure with common questions and answers about AIDS, distributed in four languages and Braille; well over half a million distributed.

In 1986, AMFAR, the San Francisco AIDS Foundation and KPIX co-produced some of those public service announcements that you saw; over 62 were distributed across the country. All of them have played in the Bay Area.

In 1987, together with the Names Quilt Project, we produced the hour long program that you saw. The San Francisco Examiner joined us in that effort. The project was supported by others in the business community. It showcased volunteerism. That was the point of the program. We encouraged volunteers and provided a brochure, again, with the help of many community organizations.

When the Quilt needed money, the Quilt Project, to take the Quilt on tour across the country, we and other businesses came forward to create the Adopt a Quilt Fund to raise money. And next week the project will feature a new nationwide public service announcement with comedian Robin Williams as the spokesperson.

And, again, we have had enormous support from people in the entertainment and television community, the donation of their time and services, the donation of photography and studio time so that this amount of material could have been done.

Additionally, our programs have been underwritten here locally from the start. One of the main supporters has been Chevron. The national effort is underwritten by Metropolitan Life and, again, Digital will be the local supporter, so that we can do more, we can continue the process both inside and outside the station.

In 1988, we will produce more PSAs, public service announcements, and will sponsor the largest fund-raiser, along with other organizations in the Bay Area -- the largest fund-raiser, the AIDS Walk-San Francisco. None of this could have been accomplished alone. It took that amalgamation of resources, effort, time and energy.

In Washington I suggested three things. I am still suggesting those same three things. One is that a national newsletter, we believe, would be of great aid or a national news wire service, if you will, could be produced. Without going into two much detail, it could be a weekly digest of the latest information, new programs, models that are working in other cities.

Right here we have a local version of that, the Media Alert, provided by the San Francisco AIDS Foundation. It is a quick and speedy way to check on information that you may not be knowledgeable about. Theirs is easy to produce. It is simple and yet it has helped us who have done a great deal to keep better informed. A national newsletter or news wire service could serve the purpose.

Again, we are suggesting a seminar to be held in the Bay Area to invite other media from across the country so that they could see the models, the information and cooperation that have taken place in the Bay Area and find it more easy to move forward themselves locally.

Lastly, we ask that President Reagan, as we did in Washington, step forward to motivate and become a visible supporter of AIDS education and volunteerism, a visible supporter of research and drug treatment and a visible lobbyist for a crisis increasing daily.

I believe that we must have support at the national level. If we do, we can tap what is best in the American spirit, what has been demonstrated here in the Bay Area, that it is possible to make something very bad better. That support means money. Some people have been very specific here at the table. I support that. And it also means a willingness to stand up.

You have an awesome task ahead of you to make recommendations but I do believe you have the power to help us all rewrite history and change the course of this disease -- rewrite the future, rather, not history.

CHAIRMAN WATKINS: Thank you, Ms. Wean.

[Applause.]

We will start the questioning from Dr. SerVaas.

DR. SerVAAS: I certainly congratulate Carolyn Wean. We need more members of the press, of the media, like you and I guess what I would like to know is if you could send to the Commission any recommendations you have about how we can get members of the press nationwide to do some of the things you have done.

MS. WEAN: I would be happy to send you, and I would say one -- and it is not self-serving because this campaign is representative of many organizations in the Bay Area -- is to encourage television stations, radio stations, too -- they reach some groups that are harder for a TV station to reach, particularly young people through music -- to either support this campaign, become involved in it or create a better one.

DR. SerVAAS: Thank you.

CHAIRMAN WATKINS: Dr. Primm.

DR. PRIMM: Yes. I wanted to talk just a moment about the problem of the deaf and HIV infection and, of course, full-blown AIDS. What we have noticed in New York City is there is a high incidence in prevalence of sexually transmitted diseases and, of course, teenage pregnancies among young deaf adolescents.

What can you do to broaden that base or that scope that you had? The tape you just played for us is the first time I have seen people signing in relationship to AIDS education and prevention efforts and I think that that needs to be widespread, particularly in New York City.

MS. WEAN: Well, a first step is, of course, to provide the informational spots with signing. We have done that. I think we also need to look at programs and make sure that they are close captioned or perhaps have signing, but another may be to provide the materials that we have to organizations that do reach the hearing impaired.

We have provided these materials to Catholic Television here in San Francisco and to the San Francisco Unified School District. So that may be another way that they can take these materials that would be very expensive for them to create, but then adapt either by putting close captioning in or using signing, so they could be useful to their groups.

DR. PRIMM: As you know, many of them don't read and it creates another handicap for them. Dr. Lee and I both serve on a similar Lifeline Project in New York, at WPIX in New York, and I have done a lot there to try to help. If you would send me any information that you have, other than what you have supplied today, I would be highly appreciative of that.

MS. WEAN: I would be glad to.

CHAIRMAN WATKINS: Dr. Walsh.

DR. WALSH: Bob, I missed part of your testimony because I was out of the room, but I wanted to ask -- you well know of my interest in the economics of health care.

Have you yet reached a point where the combined cost of the health care of the AIDS patient, plus the group life costs that you pay when he dies, have they reached a point yet where you are feeling pressure for increase in premiums from the insurance companies or is that still a little while away?

MR. BECK: I think that the number of cases are so small yet out of our total employee population, that we haven't seen that kind of pressure. It has been more our own efforts over the last five or seven years in looking at just cost containment in general and taking all the different illness and disease -- this happened to be one that came along and, again, it spoke well of managed health care, outpatient care and educational programs. So, it fit within the mold, but the number of cases -- in fact, we have been trying to look at death certificates to see if we could find and learn something from it. As you know, death certificates don't tell you much because people don't die of AIDS, they die of something else. So, it has been hard to pin that down. We are self-insured and so we are not getting any pressure from that end of it.

DR. WALSH: Have you found any pressures, well, either in your own company or in other companies that in trying to solve and help solve the problem, you know, by extending home health care -- are you getting any increased pressure for extension of home health care to other illnesses at the same time because this is one of the things we will have to confront in our recommendations.

I don't have to tell you. You have been down there enough to know the pressures, at the Congress, of -- and also the fears of the Congress of acting on doing it for one disease without doing it for all of the diseases. I wondered whether you have developed any attitudes on that because I respect your judgment from a long way back.

MR. BECK: Well, yes. In fact, when we made the policy decision that we were going to treat AIDS like any other life-threatening illness, we concluded that when we put in programs like home health care, but with the proper controls of review and so on, that we would apply that to any similar life-threatening illness so that (a) it wouldn't stigmatize and single it out and (b) it is probably good business. So, in fact, we did do just that and it has served us well.

DR. WALSH: And that has worked well, hasn't it?

MR. BECK: It has worked well. We started, I guess, mostly with hospice and cancer in the original, and this fit right in with our process, and has served us well.

DR. WALSH: Now, have any of you -- my last question -- have any of you had run into as yet any problems or do you have policies not only on keeping these patients employed even after you know that they have the disease? Have you run into problems of promotion policies or do you, in other words, promote them just as if they are well, on the basis that you tomorrow we may have a cure? All of us know we won't, but you always have that hope. Or, is there a tacit understanding that their career advance may be interfered with?

MR. BECK: I will speak for our situation. We have concluded, again, not to discriminate on it. There are a limited number of promotions in the total population and we want to promote the best qualified. However, training is probably one of the first issues we faced. The question was, "Should I send this person to this expensive training program if, in fact, I think they may die next week or next month or whatever?" And we concluded, no, you can't deny them training. First of all, it is wrong to do it and, secondly, nobody knows what is going to happen. Some of these people can live three, four, five years. Some don't live but six months. And that would be wrong to deny them the training opportunity.

And we found feedback both openly to our video tape programs and written material, that one of the most valuable things to the AIDS employee is the ability to work and be part of the normal process. So, we have kind of discounted all of that out and just treat them as if there was nothing wrong with them.

DR. WALSH: And you find most businesses are following the same policy?

MR. BECK: I think that is what has come around now that there has been broader education on it. Our biggest concern is, as Mr. Brundage said, the smaller and medium-size employers where they don't get the information, but my colleagues across large corporate America, we are pretty much following the same practices.

DR. WALSH: Anyone else have a comment on that?

DR. LAWTON: I would like to just second one thing that Mr. Beck said about the hospice and home health care provisions. I think one of the advantages that you should certainly hear is that it not only helps the employer save cost for the treatment but also provides a more humane treatment alternative to being in a hospital. And that can benefit every medical condition, not just AIDS, and, therefore, it actually behooves the employer to have these provisions.

The one thing the government certainly could do to help, though, is -- we have been fortunate here in the Bay Area to have a very active community development, both with the Shanti Project and a variety of other volunteer groups to develop the resource capability and I don't see that happening yet in the other parts of the country. I think that to the degree that the government can help facilitate that, through public and private sector collaboration, that would be certainly advantageous.

DR. WALSH: Well, as we have seen, I think, that is another place that the private sector may lead the government yet. It is not easy but we may do it.

MS. D'ANNA: PG&E also has an antidiscrimination policy applied to both the hiring and promotional systems. AIDS the same as any other life-threatening or chronic illness. If, and only if, there is a question of fitness for duty and the person's inability to work is in question can a medical clarification be initiated. This is the same procedure for any sort of condition.

Also, I concur with Dr. Lawton and Mr. Beck on home hospice care organizations in terms of their applicability to chronic illnesses where people need minimal time in hospitals and acute care settings.

DR. WALSH: Thank you.

MS. WEAN: I would just say that our policies are very similar to those expressed about the promotion and work continuance. As long as the person is fit and can perform the job, there will be no refusal to allow them to perform the job and we would certainly provide whatever services to keep someone suffering from AIDS working, as we would provide for any other employee.

CHAIRMAN WATKINS: Dr. Lee.

DR. LEE: Mrs. Wean, the last time we saw you, you were with the beautiful people and now you are with the rich people. I can see you are well-connected.

[Laughter.]

MS. WEAN: Which side of the table are they on?

[(Laughter.]

DR. LEE: A report on your New York Lifeline: it got mixed reviews. I wonder, if you are franchising that out, whether you shouldn't put tighter controls on it. There were an awful lot of people in funny costumes singing and tap dancing while you had in the studio an immense number of extremely knowledgeable people. And the cognoscenti, who were watching it on the closed circuit video, really wished that it were tightened up a lot more. I am just reporting back to you.

MS. WEAN: I am glad to hear that. One of the advantages of the program is that we do allow people to produce it or modify the program locally, hopefully to meet local needs, but certainly what you have described doesn't sound like an advantage.

As I understand it, that was one of the stations where there was a refusal to work in the studio with people who were suffering from AIDS and that may have also influenced that particular program. I don't know that.

DR. LEE: Yes, that came across. I just want to make a comment to the rest of the people in the corporate area here to tell you how really important you are. I deal not only with AIDS cases but with cancer cases, and when their employer gives them up, that is really the straw that breaks the camel's back. In these AIDS cases, we see it triply because not only do they lose their job, their income, and their hospitalization, but, on top of their cancer or AIDS problem, they get discriminated against as well.

I would like to ask you a question. I had a brief sojourn into the business world about two years ago and really had a very awful experience with a company to whom the bottom line was everything, the monthly bottom line was everything and the employees were totally expendable. I had to resign in about six weeks, but in the course of it I began to think a hell of a lot about business in this country compared to other countries, the Japanese model versus the American model, and that really why one of your problems and one of our problems is this pyramidal system in business, where responsibility and loyalty only seems to go up the channel and the employees are expendable for the bottom line.

Is AIDS going to produce a little more sensitivity to this problem? I mean, you people have been taught very well about how your companies are dealing with this. Maybe AIDS is going to bring us a little bit more sensitivity to this problem, because if you people don't take care of your workers, there is a ripple effect that really goes through society, goes through the matrix of everything. Your role as the people at the top is so important.

Anyway, I throw that out to you. Are you still as tough as ever or is AIDS doing something to you?

DR. LAWTON: I think as one of the most successful banks in the country, Wells Fargo Bank, we are still able to have a very, I think, sensitive and compassionate approach to dealing with AIDS, so I don't think that it is incongruent to have a bottom line orientation and still be caring about people.

I think that the other side of this that is unique about AIDS is that we are seeing a very younger work force hit in their prime in terms of developing this disease and, yet, still being able, perhaps, to continue working for a period of time. So, it is forcing us, I think, in the work force to deal a lot more with death and dying issues than we heretofore had to and I think that with that may come an increasing employee concern that perhaps would be beyond any one employer's control and/or even philosophy.

So, I think that there may be some indirect benefit of this disease, as hard as it is to find, that may perhaps make us care more both about our employees, but also to really forge this greater public/private sector collaboration for other diseases that need to be addressed, where we are having to look for very limited health resources.

MR. BECK: I guess I can speak because we were probably the most publicized corporation in America in 1986 as Bank of America has been going through a restructuring and a turnaround. We were often criticized by the Wall Street analysts that we didn't take the wholesale approach and do it like an immediate swift sword and lay off thousands of people and so on.

We didn't do that. We took the longer approach. We think the longer approach has the long run attitude about your whole culture, your company and how you actually look at employees -- we are a service business and our people are our most important part of the business or most important asset. You can say that in annual reports but the proof comes in the pudding when the tough times come. We have treated our people in a humane way. It would have been easy to say, "AIDS is not a problem for us; we haven't got time to deal with that." You can see we didn't take this path.

I saw no problems with our top management wanting to take the time for meetings or even publish brochures. I think it is a philosophy you adopt and certain companies go in one direction; others go in the direction of the companies you have seen here mainly in the Bay Area.

As far as the sensitivity to employee well-being, I have seen a shift. I am a member of top management and have worked on both coasts. It turns out that the health care crisis that we are now dealing with, the shift away from the diseases that we had in the early 1900s, which were the public health systems and government's responsibility, have come about now through the health care cost crisis in the country. You now see the CEOs of America saying this is a major business problem. The focus now is "How do we solve it?" Now we are forced to deal with education of the work force to make the system more efficient and more effective.

I see that now. It is harder to get more senior executives interested in child care, but now along comes something called Elder Care and they have older parents; or they have children who are working, -- their own daughters or their sons -- who have child care problems. So, the awareness of what you might have originally called social issues are now becoming clearly business issues and groups of CEOs are now getting together and saying let's help solve this problem rather than that is the government's problem.

So, I see a tremendous change in the seventies and eighties to the -- they are no longer just social problems; they are country problems, but, yes, they are business problems.

MS. D'ANNA: I would like to address the issue by elaborating on some specific concerns that we have been getting from management and supervisors. I think one of the things that the AIDS epidemic is doing, if there is any positive gain from it, is definitely stimulating conversation and thought and getting people to think in ways that they have not thought and questioned before.

We had a manager who called and who was asking questions about the fact that an employee who is a very well-liked employee, who was a star performer, whose performance was deteriorating as a result of the fact that this person has AIDS -- the fact that he had AIDS was known to the work group and the management -- questions concerning the dilemma of wanting to provide an atmosphere that is productive and having the same kinds of work and staffing demands that are necessary to get the job done.

The fact that companies are discussing that, and using their resources within the company to help consult about issues of this nature tells me that attitudes are changing and people are opening up to other possibilities with respect to care of people with AIDS and other life-threatening and chronic illnesses.

DR. LEE: Could I hear from the Chamber of Commerce on that?

MR.BRUNDAGE: Yes, my comment would be -- I travel the country quite a bit to other Chambers of Commerce and speaking for the corporate community in San Francisco, they are clearly light years ahead of other cities of this size. The human services in San Francisco to a large extent are funded through corporate contributions. That simply doesn't exist in other cities, to my knowledge. It continues to be amazing to me as the months and years go by that this is not part of the rest of the country.

But, indeed, the corporations here have set the standards, I think, that the rest of the country can certainly pay attention to.

DR. LEE: Mrs. Wean, what do you think about the Lawrence Tisch approach at CBS?

MS. WEAN: The Lawrence Tisch approach as far as his running of the company or --

DR. LEE: Well, as far as his approach to -- do you have his approach towards your employees?

MS. WEAN: I hope not. I think television has been late to come to some of the economic issues that the banking industry and the medical industry have been facing in the past couple of years and one of the incredible difficulties that companies in television are facing -- and perhaps Tisch is an example of that -- is that with mergers and takeovers that companies are being run differently.

Certainly, I can appreciate his need to run the company more efficiently and that the news product itself could be still salvaged and be very good even under those circumstances, but the difference did seem to be -- if you look at the NBC, and I hate to talk about this because it is the rival network, at least in my incarnation at this station -- laid off just as many people, but for whatever reasons, because they handled it better, received so much less censure in the press and presumably because they treated the people better.

So, I think you still have to make the tough decisions when they come but it is how you handle the people and how much concern and real financial help you can give them in relocating that counts.

DR. LEE: I won't ask for any answers to this, but I want to throw out one other thing to you as prominent members of the business community. It seems to me that this takeover business is at the heart of it all. The malevolent takeover business is what I saw happen: a fine company was just destroyed, so that its assets could be used and a certain number would appear on the bottom line. This is bad for our whole system.

MRS. GEBBIE: I would agree with, I guess it was your comment, Mr. Brundage, that people here are doing it right. When I look at the applications elsewhere, I have a feeling that the typical business person might say that those are all blue collar companies. I know you are not entirely, but that is an image -- that these are all large corporations, not small ones, or that that is California and you just have to sort of excuse something because it is California.

You all said this should happen elsewhere but I didn't hear any real specifics. If you were in charge of the world, what would you recommend be done to get the small employer, the middle size employer, the employer in the smaller city, who doesn't have a huge human resources department, doesn't even have a full time anybody doing some of the things you do, doesn't have at a media station a large resource for doing public service things. That is something you sort of do on the side or as a part time assignment.

What specific would get them launched in some of these very effective and important programs you are working on?

DR. LAWTON: I think one of the first things that has to be looked at is the social stigmatization that has occurred around the AIDS issue and the difficulty many people across the country have had in dealing with the AIDS issue and I think that that can be changed very easily by having people such as President Reagan, having CEOs, having community leaders, such as the Chamber of Commerce, at the highest level in the community, to come together, along with the religious leaders in demonstrating that through moral leadership by addressing this issue collectively, we can really stop the spread of AIDS.

I think the first thing is that you have to normalize that it is not only appropriate but necessary for senior people across the communities at large to get involved. And I think that you can capitalize on existing communities where that has occurred, as well as existing leaders around the country where that has occurred.

In spite of the fact that San Francisco was one of the first communities to deal with that, there now are many corporate leaders around the country -- Allstate Insurance being one of them -- that have demonstrated this leadership.

I think the second thing that would be important is to not have to reinvent the wheel. We have a lot of resources that have already been developed and actually proven strategies, both here in the Bay Area and perhaps other parts of the country. I think to the degree then that the government can facilitate that kind of resource sharing and basically bringing, either through financial grants or supports, proven experiences to bear in those communities where something has not occurred, I think we have another opportunity, if you will, to enhance or speed up the delivery of AIDS prevention.

I think the other thing, again, just to reiterate around the National Leadership Coalition, this is the only public/private sector-led coalition that brings the church groups together, the private sector together and a lot of the gay groups at a national level together, in addition to the American Medical Association and the Centers for Disease Control.

Forums like that, which allow for, hopefully, debates about some of the very difficult ethical questions that we are going to be facing with AIDS and, hopefully, trying to come to some consensus can, I think, further stimulate both the decision-making necessary in terms of resource allocation, as well as in terms of trying to get basically people on board.

I think, finally, I think I would like to just reiterate what Mr. Brundage said. I think the Chamber of Commerce has such a wonderful opportunity to set the leadership for the small employer and if we could perhaps capitalize on the excellent leadership that the Chamber here in San Francisco has demonstrated and somehow promote that kind of same example in other parts of the country, I think we can really do something in a very progressive manner.

MR. BECK: I would like to just carry that one step further. I think most large corporations realize that most of the jobs that are created in America in large numbers have been created in small businesses. That is where the growth is. They are our customers as well.

As we realize that, we also realize a lot of the innovation in America comes from small businesses not large corporations. So, it is in our best interest to see small businesses thrive and flourish. We are concerned about the unreimbursed and under-insured in those groups. I think in this case when the Business Leadership Task Force, which were the top 15 employers in the Bay Area, got together and we made the brochures, we made the guidelines in the work place and we made the video tapes, we decided that, well, that is well and good for us, but isn't it right for us to give it to all the rest of our colleagues. So, we held a symposium that was free and we gave away the materials free in the very beginning. Then we donated the rest to the San Francisco AIDS Foundation to be the channel of distribution because we didn't have a way to do it.

I really would like to see that kind of thing happen across America. Corporate America does have the resources. Sure, we are all going through tough times; us being a prime example. On the other hand, there is just a certain amount of that community responsibility. We adopted that with child care. We decided it was wrong to have companies build their own child care facilities; let's build up the community. And the same has been true with wellness.

Instead of putting in a lot of fitness centers, let's build up the health facilities of the town, whether it be the YMCA, YWCA, whatever. I think that community partnership has just got to spread. It is too big of an issue for us to do it one off. We have to do it in a partnership mode.

MRS. GEBBIE: My other question, we have talked a lot overall here about the whole connection with drug abuse and this epidemic and that hasn't been mentioned at all in this discussion with business. It is my perception that businesses are struggling a great deal with the whole issue of drug abuse in the workplace and that it might almost be harder for the person who is HIV-infected because of a drug-related exposure, who has managed to keep working, to come forward and ask for help than the person whose infection comes from sexual activity because it is a triple jeopardy or something like that.

Are you identifying that overlap in the work site, are you seeing that as a problem? What are you doing about that?

MR. BECK: Yes, in fact, I was going to say earlier that when you expand a program like this nationwide, you do have to tailor it. If you look at the cases in San Francisco, it is predominantly involved with the gay community. Where we found -- we have a lot of employees in New York City as well and we find just the opposite. It is not predominantly gay, it is the IV drug users, which then tells you a whole different audience because now it is taking it to children and mothers, which we didn't see in San Francisco. So, I think you do have to tailor it to your audience.

As a side note, on the drug and substance abuse, that is of major concern to us. We are putting far more effort now in trying to solve the substance abuse problem not only of our employees but their families because we pay the medical bill. We have stepped up our substance abuse program tremendously to where in the last two years we have tripled the number of people who have come forward and said I need help because we have made it okay to do that through educational programs. Also, by getting into case management, identifying and recognizing the problem and dealing with it, like we have done with AIDS, we have cut the cost per case at least in half, in fact, it is almost a third now.

DR. LAWTON: I think, coming from the Employee Assistance perspective, the concern about focusing solely on IV drug abuse is that we could miss the other substance abuse problems that leads to people exercising poor judgment and putting themselves in potentially dangerous situations sexually or otherwise, where they may be exposed for HIV infection.

So, I would hope that one of the things we might do would be, one, promote further development of the EAP programs that can help people confidentially get assistance around the substance abuse problems.

In our earlier experience, we don't find any further stigmatization, if you will, if they have a drug problem and also have HIV infection. Unfortunately, we are beginning to see women who are contracting the HIV infection through sexual partners with somebody who is an IV drug user here in the Bay Area. So, I think we are beginning to see the heterosexual becoming infected through perhaps no fault of their own in terms of their life style habits.

I think one of the things that we certainly also need to begin looking at is the overall problems that the smaller employer has in terms of gaining access to treatment in the community. We know that no longer is there only a problem in getting treated for heroin addiction, but there seems to be an overall limited access to substance abuse treatment for people either in terms of inadequate health coverage or no health coverage at all.

Until we are really willing to face that problem, I think we are going to have further difficulties in stopping the spread of the disease.

MS. D'ANNA: We have quite an extensive drug awareness and education program at Pacific Gas & Electric Company and an employee assistance program that provides resources for treatment and assessment for those types of problems. The availability and accessibility of the program is conducive for people to come forward, based on its confidentiality and credibility.

So, in those educational programs we address the issue of AIDS as well. Additionally, we talk about new high risk groups, including teenagers, who are vulnerable to experimenting with sex and drugs for the first time without knowledge and so in that way work with parents to become more aware of the problem with the kids.

So, it is addressed within the company in two different programs and integrated into related programs.

MS. WEAN: I would like to share a few thoughts that I think at least discuss the question. I don't know that I have any answers to the one you just asked.

Certainly, in the Bay Area, there has been a great response in a variety of ways to deal with the AIDS crisis. Dealing with the spread of AIDS through IV drug use, it seems to me that we have to attack the root of that problem, which is different, which is different, which is drugs and substance abuse. And that is an incredibly difficult one to change behavior. First and foremost, there is no particular constituency or lobby to speak out for programs for drug users and it is, I think, even beyond AIDS, which I live in hope of that we will be able to have a medical solution to at some point, that there is no solution to really look forward to, such as a vaccine or a drug for IV drug use and that while this is not your mission, I know, that it is so connected to AIDS that part and parcel of the solution to AIDS has to be and may, in fact, give us a benefit on another front, which is to attack directly the use of drugs on all sectors of the society with increased funding at the federal level for programs with the support by businesses of programs with their employees and support of media campaigns, such as we and many others have done.

MRS. GEBBIE: Just as a final comment, and your comments triggered that, our preliminary report included a section on drug abuse prevention and treatment and I am not sure that we focused particularly on how that related to the business community. I would be very appreciative of any comments you would make as a result of reading that section, if we would be sure and get it to you, and read it and see whether in our final report we should adapt it or change it to cover that tie in to the business community.

CHAIRMAN WATKINS: Dr. Lilly.

DR. LILLY: You have told us about the rapid evolution of your policy with respect to employees who develop AIDS and presumably are positive for HIV antibodies. I am just wondering -- I think San Francisco is probably the best place in the world to ask this question, given the nature of your population here, how that interacts with your policies on discrimination against homosexuals, for example. Again, I suspect that being in San Francisco, homophobia has been a very minor factor in your operations. On the other hand, that is not true worldwide and I am just wondering if you have any comments on the interaction between AIDS and homophobia?

MS. WEAN: Well, with specific reference to our policies, our policy is not to discriminate against people because of their sexual preference.

DR. LILLY: Did you have that policy before the advent of AIDS?

MS. WEAN: Yes, we did.

DR. LILLY: So, that, in a sense, probably helped with respect to developing the policy with respect to AIDS.

MS. WEAN: And I certainly think so and also at KPIX, and I assume at most media outlets with a diversified work force, you would be more inclined to find compassion because of proximity and the people associating with each other who have different life styles.

I do think that we would be blind not to say that there have been outbreaks of homophobic behavior in the Bay Area and certainly I have seen and heard of others that are even more severe across the country.

MR.BRUNDAGE: Representing a cross section of corporate people in San Francisco, it simply has not been an issue, hiring discrimination of any type based on homosexuality. In the last ten years, I can't remember that issue ever surfacing.

DR. LILLY: You are talking across the country. I am astounded by this. Please repeat that.

MR.BRUNDAGE: No. If I said across the country, I am sorry. I was speaking just for San Francisco.

DR. LILLY: Oh, okay.

MRS. GEBBIE: You thought Nirvana had arrived or something.

[Laughter.]

MR. BECK: First, San Francisco did pass one of the earlier laws against discriminating against sexual preference and California has had a pretty tough law for a number of years on not discriminating against medical disabilities of any kind. So, when you put the two of those together, we have been dealing with that, at least in California as a nationwide and a world employer. We adopt the same policy for California as we do everywhere and our managers know that. So, it hasn't been an issue for us on a national or an international basis.

In fact, worldwide, our biggest problem is that the networking and support systems are here in this country to a far greater extent than they are in many of the countries of the world. We, Americans, are criticizing our governments at the state, federal or local level for not doing enough. Still, there is a tremendous support structure we can all draw on, whether it be the Centers for Disease Control or the university systems or what have you. So, our bigger problem overseas is where do you turn to for advice and counsel and support.

CHAIRMAN WATKINS: Dr. Crenshaw, do you have any questions?

DR. CRENSHAW: A combined question and a brief comment.

Many corporations have services for the counseling and help of their employees who have emotional difficulties and problems. What I am wondering is in relation to the HIV epidemic, what can you do or what thoughts do you have on how you can improve or increase the counseling resources available to people, not only who are infected, but also those who are having relationship stresses, relationship problems, social interaction, social skills, dating skills, all of these things that precipitate the kind of personal problems that result in high risk behavior?

That seems to me to be an underappreciated area and I know the resources are in place. What can be done to magnify their impact?

MR. BECK: Again, coming back to the philosophy that we shouldn't have our own, we haven't tried to staff up for various reasons. One, we don't think that is our business and we know that much about it and, secondly, with branches from literally the Alaskan border all the way down to the Mexican border, we couldn't staff it anyway inside the company. So, we have adopted the approach to utilize the community resources and what we have tried to do is working. We also don't know how to judge the quality and that was one of our bigger concerns originally on substance abuse referral, that we were referring to what? And, so, where we need some help actually is the better certification of standards, whether it be child care or elder care or even medical care in certain areas.

What we have tried to do is turn to the bodies where we have some respect and some certification and then advertise that because a lot of our people when they come in, don't know where to turn. That is the biggest part of the problem. So, we follow the resource referral approach on all these issues and the more we advertise it, I think the more that gets it out there. All they want to know is some assurance that the company cares enough to help them and even to some extent financially, but not totally. I think it is a communications issue for us. We will help by saying we want to help and we will help you get to the right help, but we are not going to provide the help ourself. That is not our role.

DR. LAWTON: I would agree with everything that Mr. Beck just said. I think the other thing is that we can utilize the United Way resources that are throughout the communities and try to make sure that people know how to access them even if they don't want to go through their company EAP.

I think we also can, perhaps, expect our employers to begin making a greater amount of contributions, either in-kind services, or financial, to try to support the development of resources where there are not any in the community; for instance, something around the Shanti Project, which is relatively unique to the Bay Area.

So, I think that there may be some unique kinds of resources that may need to be developed around the HIV infection and they can be developed through sort of a combined, again, collaborative effort between the public and private sector.

MS. D'ANNA: Well, it is obvious in San Francisco there is not that much of a problem in terms of the resources that are available to people and access to those resources. We have just been involved in a discussion with the company about whether to promote early testing of HIV and the decision was that we shouldn't be in the business of promoting anything but to provide information for employees, so that they can make a decision about whether or not they should get tested or what. We provide them with brochures on HIV testing, as well as a whole packet of places throughout the state, where people can get testing. We support the test sites that include counseling along with it.

So, that is how we have addressed that particular issue with HIV.

DR. CRENSHAW: Do any of your corporate insurance plans pay for mental health coverage? What percentage?

MR. BECK: 80 percent.

DR. CRENSHAW: 80 percent. And what is the ceiling?

DR. LAWTON: $1,500.00 per year for outpatient treatment.

DR. CRENSHAW: $1,500.00 per year for outpatient. Thank you.

MS. D'ANNA: Ours is $1,500.00.

MS. WEAN: Ours is considerable. I can't remember it, but since I have used it, it has been considerable.

CHAIRMAN WATKINS: Dr. Primm, you have a follow-up question?

DR. PRIMM: With people who have infection, for example, and who might in your companies manifest some dementia, how would you handle that kind of situation? **MS. WEAN:** Those would be difficult situations, but you would have to handle it the same way you would any other. I have never been faced with that particular situation --

DR. PRIMM: I think we are going to begin to see some of that.

MS. WEAN: I think so, too, but I certainly have faced situations where there were emotional problems on the part of employees -- I wouldn't classify it as dementia -- that were severe enough to impair their ability to do their job and we insisted that since their job performance was at stake, since legally that is what we can do, but also as human beings, encourage them and help them find treatment.

What you are suggesting would be more severe and if it is long term, would be a form of behavior that you would have to, I think, look towards disability, just as you would for any other kind of incapacity.

MS. D'ANNA: We have seen degrees of cases like that, and basically we take every individual on a case-by-case basis, following the general guideline of initiating a medical clarification if the person is visibly showing signs that they may be unable to do their work. However, each environment has different needs, and each employee has different needs, and it is crucial that we not have any cut and dried answer, but that we look at it on a case-by-case basis.

DR. LAWTON: We also would look at it on a case by case basis. When job performance was impaired, related to that or suspected related to that, you would be referred to our Employee Assistance Department to have confidential evaluation of it. We would refer it to outside medical resources, probably have a neurological exam to find out if the person was, one, fit to be able to work and if so, but if they needed to have some form of job modification, we would then look to see how we could modify their job.

We have already done that several times and what we have found, for instance, is that people sometimes have problems with abstract thinking, difficulty with concentration and by just changing the nature of their work, they have been able to successfully continue working, up to now anyway. I think that ultimately at some point they might have to go out on disability.

MR. BECK: I was questioned by our advertising department recently because an ad has been running in a national magazine that says "Mentally Retarded People Work Here," and they listed three or four companies, ours one of them. That bothered them and I told them I obviously didn't place the ad, but the concern -- well, it happened to be a company we are working with who -- we have certain kinds of jobs where there are relatively low skill mental requirements and these people can be very productive in society. And it is working out beautifully for us and for them.

My comment is that we go through job accommodation first. We go through that whenever there is any kind of degradation, even in physical disability. We have, on occasion, put terminals in people's homes and they can work from their homes. So, we would go through that thought process first. If it comes down to it to where they are just incapacitated, then they become disabled and go under the disability plan.

CHAIRMAN WATKINS: Mrs. Gebbie, you had a follow-up question?

MRS. GEBBIE: Maybe one of these answerables.

Several of you talked about not wanting other companies to reinvent the wheel and let's share resources. I say that a lot, too. I guess once one health department in Oregon invents something, I think we ought to share it. But, in fact, everybody that gets something then wants to redesign it for their own place. It is not in the right format or it uses the wrong verbs or their company lawyer hasn't read it or their local district doesn't like that word or something.

Can we find a better way to describe that process of tapping the resources that exist but still acknowledging that need people seem to have to work it through to make it their own or am I misstating what that process is that we go through? If you hadn't had a policy yet, would you take Mr. Beck's and just change the letterhead and mail it out?

DR. LAWTON: I think BofA's policy is an excellent one and I might be willing to do that, but I think your concern is accurate. I think every company, every employer wants to personalize a policy to their own culture, to their own employee population, to their own management style. I think that is not only necessary but very appropriate to make it successful.

On the other hand, one of the things that both our company, I know BofA and PG&E and many others have found is that many employers are hearing through word of mouth or through the media that we have been involved in addressing this issue and are asking for a copy of our policy. In light of that recognition that people don't want to reinvent the wheel, I think that people are finding it valuable to know how to find the resources. However, I don't think it is as easy as we might think to sometimes know where the best resources are or where people, perhaps, have been most likely able to get the kind of experience they need to address their unique problem.

So, the Allstate Forum attempted to try to address that with their publication on Corporate America Responds on AIDS. It would be wonderful if there was a way to financially afford to make sure that every employer had a copy of that report as one example of trying to get some sort of standards, if you will, or some proven successful models out there so then people can then modify to their own liking.

MR. BECK: Something is changing. It is called deregulation and international competition and it has taken a lot of the companies, who used to have fairly good profit margins and they always wanted to have their flag on the top and reinvent the wheel. I have seen a big change in that.

What they can't do -- I wouldn't think that Wells Fargo would want to take Bank of America's video tape that says Bank of America all over it and show it to their people. What is happening, though, is this consortium idea, that we did all get together in the Bay Area and we made one video tape and at the end it says this was made as a result of contributions from and then it listed all of us and we all know that we can either turn it off or turn it on at the last scene.

So, the brochures, the videos -- and I see that now in child care. I see we are starting to do that work in elder care. We are starting to do that with work on the uninsured and underinsured in California, trying to work together and not try to get either a single credit for it or create just something for our own work force. And I think it is because of this profit squeeze we are all in from a competition standpoint. So, that is probably working in a positive way even though we didn't plan on that.

MRS. GEBBIE: Thank you.

MS. WEAN: I certainly agree that the private squeeze may have taken some of the ego out of reinventing the wheel from the ego massaging that comes from that. The other thing that -- while I am part of a large corporation as the manager of KPIX, we are still a relatively small by numbers of people business, which is about 265 on a given day, 270, which compared to the total corporation is small. And we are on the West Coast, 3,000 miles away from our headquarters and where many of our operations are located. So that we had to approach AIDS education from within, much as a small-to-medium business. And we were only able to do that effectively, because it simply would not have worked to have brought people out from the East Coast -- and if you think people take pride in the corporate logo, people on the West Coast in television take pride in inventing television, but we were able to take advantage of community resources and programs that were funded by some of the people at the table. So, that consortiums are incredibly important in not reinventing the wheel.

DR. LAWTON: One last thing. I would like to just clarify that I know BofA and Wells Fargo, any larger corporation that has a geographical dispersion of their employees sometimes can't even have just one approach even for their own employee group. So, you have to, again, sort of tailor it to the unique culture of that geographical location and that employee population.

CHAIRMAN WATKINS: I will close out the panel with a couple of questions.

If we just focus on California, maybe we can get an answer from Mr. Beck and Dr. Lawton and Mr. Brundage. What percent now of corporate business leadership would you say in California -- and I would take it all the way down and maybe you have to break it up into larger entities, as opposed to small business and so forth -- but what percent are now involved, what percent were involved two years ago and what realistic percent should be involved? Where are we right now? What is the involvement at the CEO level that feel serious about it, that is going to educate in the work place to allay fears, to ready the work force for the first arrival, if it hasn't already taken place, to keep the funding going for group insurance, to keep the person in the job along the lines you all laid out? Where are we right now? Where were we, and what is realistically achievable?

MR. BECK: You want me to take a shot at that?

DR. LAWTON: Yes, try it.

MR. BECK: I will try it first. First, CEOs, and I have worked with quite a few of them on a lot of different topics, get interested in certain topics, whether it be health care or aging or child care or the educational system in the country. What you find is they take it more as their thing to work on during their reign as top management. So, you network with those and you know which ones are, as you talk to your colleagues across the personnel community, and you get them involved.

So, I don't expect to see a widespread -- take the Business Roundtable -- all the CEOs getting involved in this topic. They won't. We have tried it. We have tried it with minorities in business and all the other different issues. So, that is not a real good measure.

But let's take San Francisco. I am going to make a guesstimate because of the attention we have given it in this town -- our business group on health has over a hundred employers, including school systems in the five counties -- I am going to guesstimate that we are somewhere in the neighborhood of 60 percent and that number sounds low, but we have a tremendous growth of small, very, very small businesses in the San Francisco Bay Area. We have lost major corporations, about 23 of them, in the last four years and it has been replaced -- our growth has been the very tiny, small businesses. That could be as high as 70 percent with the work the Chamber is doing now.

If you take California and particularly southern California where most of the growth is and a high percentage of the population now, we have less impact. We are having less penetration on the issue. First of all, take Los Angeles -- you know, San Francisco is only 750,000 people and Los Angeles is about 10 million, but they are so scattered it is hard to find a central unit, like our downtown district, to deal with it as a community. You don't have the same community to network through.

I am going to guesstimate, that in Southern California it is probably more in the 30 to 40 percent and these are pure, just pure judgment off the top of my head from experience. And then when you go nationwide, it is going to drop down even a lot further.

CHAIRMAN WATKINS: But you both agree that those percentages as generally reflective.

It is clear to us that you are more involved here than we have seen in any of our site visits, without any question. We have seen some places totally devoid of any interest on the part of corporate leadership to really get involved at this point.

My next question would be, as a Commission, what can we do? Three Commissioners here attended a meeting of a Business Council in Homestead, a full day devoted to AIDS and drug abuse, unusual for the Business Council leadership to spend that kind of time, very worthwhile. We had a moderator in Ted Koppel. We had competent clinicians, technical people on the panel. It was an all day session.

I was a participant with you in the Allstate Forum, where pleas were made that AIDS education in the work place can be the most powerful vector for adult education of Americans. And you have set yourselves up as kind of role models out here in a number of areas in your progressive and positive and compassionate and sensible approach.

The President has private sector initiatives. I have not seen it come out with anything to try to pull together groups like the Conference Board, the Business Council, the Business Roundtable, the National Alliance of Business, the Small Business Association, the links to the roundtables in the states or their equivalents, the Chambers and so forth, at that kind of level, to really go at this thing and say we are the education arm of the work place. We have the models. We know how to do it in a lot of corporations of various sizes. We are willing to come together and find out a better collaborative technique to reach small business. Why can't you all be the linkage? Much as we are asking other partnerships to take place, why isn't there a business-to-business partnership arrangement that can be worked out?

If that can be done, perhaps there can be in part of the educational material we recommend to the President some sort of incentive package that would stimulate that process. It just seems to me that we need some more specific of recommendations from you as to what we can do to enhance that process because you really do hold a key to one of the doors of the kingdom on education without any question, or you could hold it.

So, I am trying to find a better, a more discrete set of recommendations that we might consider coming from you all that would enhance that process and get it moving more uniformly across the nation and with more enthusiasm at this point in time.

DR. LAWTON: I would like to comment, Admiral Watkins. I think you are totally correct in your perception.

Part of the problem has been that I think the private sector, at least around the AIDS issue, was waiting for the government to take some steps. The very fact that the Administration was not willing to call for any kind of urgency on the part of the private sector to do something, I think, perhaps allowed us to take a more passive approach. One of the things that I think promoted something here in the Bay Area to address it was partly the competition that we all had between each employer in wanting to try to maintain a certain kind of progressive stance.

It was also, I think, the fact that the problem was sometimes addressed by middle management and then brought up to senior management. So, I think that the problem somewhat was not necessarily led by CEOs having a vision right from the start as to how it should be best addressed. I think, though, that things are in a different place at this point where we able through the collaborative efforts of the forums, which did have access to the CEOs, like the Business Leaders Task Force, the Couflinger(?) Roundtable, et cetera, that we could probably now get more people if there was some very clear direction by the government, that this was an appropriate and necessary role. I don't think that that message has been clearly --

CHAIRMAN WATKINS: Do you think you all agree that it is an appropriate and necessary role?

DR. LAWTON: I would say definitely.

MR. BECK: I think that is part of it. We saw that on the alcohol and drug side when some of our national figures came out and said that they had the problem, admitted it and it was okay to start to deal with it without putting it underneath the table. I think that is part of it.

The other one is that most CEOs that I have dealt with, and they are the large ones, they are faced with terrible dilemmas of trying to keep their companies alive. Dr. Lee talked about the incredible takeover problems, tremendous pressures on them and, yet, they have got constrained resources. We are out of the era of the fifties and sixties with unlimited resources. So, I have to prioritize everything and I have to do what makes sense right now for me.

People have asked how I have been so successful in selling both IBM, when I worked for them, and now the Bank of America on doing a lot of these programs and it sounds harsh but it comes down to the basics. We can't afford not to deal with the drug abuse problem because it is costing us, but originally we didn't know it was costing us.

Hypertension was costing us and we didn't know it and so AIDS is costing us. It is costing us productivity because of the concern in the work place, the fears, but also the cost of that care. If we were paying 50 to a hundred thousand dollars a case versus $20,000.00 a case, that is -- they can talk those numbers and for no other reasons, you have to do it for that. So, if you try to go in on a "do-gooder" basis, it won't work. We don't have enough of those resources as we did in the fifties and sixties. We are doing it because it is good business to do it, whether it is child abuse, we are dealing with that. We are dealing with all those what used to be called "social issues" because they are now "business issues."

I think to the extent that you can help say that it is okay to deal with it, you'll be more effective. I would deal with the CEOs just like I have in these other programs -- give them the fundamentals. I tell them, "It is part of your business and if you don't, you are going to pay for it anyway." So, why not jump in and get involved and support it and manage it?

The CEOs of the fifties and sixties tended to be what the business schools called managers, coming back to Dr. Lee's comment. The managers in a lot of businesses aren't making it now. It is the leadership factor. We are finding out there is a difference between management and leadership. The leaders think of the broader community and not just the business they are in and now you see this enlightened CEO leadership orientation, which says this is my responsibility.

DR. WALSH: Jim, if I may make a comment, out of fairness to the President and the Private Sector Initiative, I was on that board and the Private Sector Initiative did adopt a position and the President did issue a statement on their behalf. Unfortunately, it was in Venice at the time of the summit and it got very little attention but the members of the Private Sector Initiative board insisted that a statement on AIDS be made and the President did make it.

The sad thing, however, is that the very companies that insisted that he make it are doing nothing in the private sector field, including your old alumnus because I know I was up there at their invitation over a year ago when they were first running into a significant number of cases and deaths and they asked me for suggestions. And I tried to persuade them at that time to put in the type of program that you are talking about, or you would have put in if you were still there, and there was a lot of rationalization of why it was premature.

Now, I have learned that just recently they have decided maybe we had better do something and they have distributed their first piece of literature to all of their employees. But the sad thing, and this is what Jim and I were mumbling about when you all were talking because he and I both are interested in the same thing. It is so true that it is a great opportunity for the private sector to solve its own problems and yet because of the nature of the disease, they are not looking, as you have looked, at the fact that is not only AIDS. It is hypertension. It is cancer. It is all of these things. It is a new method of health care, which AIDS has wedged in.

They are simply not looking at it that way and you in California, regardless of what pressures forced you into it, it was a blessing from whatever -- whether the pressure came from the gay community, it doesn't make any difference. You had a benefit from this horrible problem that the rest of the country still hasn't realized.

I don't know how you guys are going to sell it to them but I have mentioned programs from here frequently when I talk to CEOs and I was down with Jim at that Business Council meeting and Jim Burke was the program originator of that because he felt they weren't recognizing it, but I can't speak for Jim, but my feeling was that despite the eloquent appeals that he made, the eloquent appeals I think that we all made, there was -- I didn't feel -- I can't speak for Jim -- but I didn't feel any response on the part of the CEOs that were there that they felt it was time yet to do anything.

CHAIRMAN WATKINS: That is the same feeling I had. I felt the same way. There was individual enlightened leadership without any question. You know who they are. They stand out like sore thumbs and they are some of the brightest and best we have in the nation and they are very much ahead of things because they have been ahead with health promotion programs for their own companies and their employees and so forth. They have been watching this for years, even before AIDS. They are doing a tremendous job. They are still outspoken, so way out in front.

The question is how do we take advantage of this opportunity and make a recommendation to the President that maybe he can spark a much more aggressive and total movement across the nation. I mean, what is it going to take? Is it just national leadership, a new networking regime, or a new tie-in with a variety of other organizational entities? How do we promote such an involvement and movement nationally?

DR. LEE: Jim, isn't the carrot really productivity?

DR. LAWTON: I think it is cost. I think that the one thing that Mr. Beck said that is so critical is that part of the thing that forced us in the Bay Area to do something was our self-interest. We knew that we had a lot of employees, whether we liked it or not, who were probably at risk for this disease. We knew that we could not ignore it. So, I think that one of the things that is happening to many employers that I have heard across the country is they are still into denial. They are saying it is not going to affect me. We don't have anybody who is having these kinds of life style habits. We don't have any reason to believe that we are going to have to deal with this in our community.

They are also concerned that the customer will somehow have some form of a negative backlash, that there will be a bad public image if they address this problem. So, I think the first thing you have to do is somehow point out what the numbers really will be in the community. For instance, even if they themselves in their employer population don't have the problem, they are going to probably have to bear the costs of the treatment, either in their own community through increased taxes or on a national level through increased taxes.

I think by somehow emphasizing what that cost might be, they may get more motivated.

CHAIRMAN WATKINS: Can you give us -- maybe the three of you -- give us any cost analysis work that you have done within your own organizations you are willing to share with me that says this is what we believe our cost offset has been by our own program?

MR. BECK: In fact, I put that in my report.

CHAIRMAN WATKINS: That is not self-serving. I want it as objective as it can be so that we can perhaps use that data and state that there is an amortization regime when you do things in prevention instead of remediation and we have never put data on it. We have a requirement to put out a financial report and we have to get some kind of an indication of whether prevention is worth anything from an economic point of view.

You seem to think it is. Your companies seem to think for a lot of reasons, both the social support network for your people, for their morale, the work force is up, your efficiency is up, you have got that compassion sensitivity of the work place for a variety of things, other than AIDS. So, what is it worth to your companies? Obviously, you think it is worth a lot. It must be worth it to other companies to at least plan for the eventuality. They don't even have to execute it today, but to sit down and plan and talk about it, which would do a great deal for the education process and it doesn't have to cost a lot of money today.

MR. BECK: The productivity is not one we can deal with because no one that I have worked with comes up with a real good way to measure productivity, particularly in the service economy in the white collar area. We did include in our paper our medical cost, which as I said was $17,000 going to $25,000 versus the national averages.

I think to be fair you would have to add to that, as we did to our hypertension education studies and what have you, that since you are losing a lot of these employees at a very young age, but long enough, let's say in their thirties or forties, that you have got to figure some investment costs if you hired them out of college in the 22, 23 -- we didn't include that in there. You would have to come up with a number of some reasonable training cost investment. If you add that to the medical cost, that alone, I think, will be a big enough number.

I would have probably started your conference in Florida off WITH $100,000 or $25,000 and then multiply that times x, whatever it is, and that all of the sudden gets CEOs' attention, versus talking about what the cause of the disease is and how to prevent it at this point.

CHAIRMAN WATKINS: I couldn't agree more and I think that the trouble is that we try to be sensitive to the human being at the end of the string and it is very difficult when you get into cost benefit analysis to get very sensitive to the human being that is hanging out there on the end. So, we are walking the line in our debates, so that we don't give the impression that we are not sensitive to the humans.

I think if the three of you, independently, would go back, if you would, Mr. Beck, and take the data that you already have and maybe fine tune it along the lines you suggested it would be helpful. The more that we are realistic about the figures, that we are not self-serving and so forth, the better I think it will sell with other people who review your data and say, "That looks logical to me."

But certainly there is also the cost of not doing these things nationally. Today, we have something like a $63 billion annual cost for dealing with these same individuals, who aren't in your workplace, for a variety of health reasons, and we have a lot of other indications that perhaps there are some off-setting dollars there, if we can just sustain ourself long enough to get into a steadier economic funding stream.

I think too often we just look at up-front investment without the amortization regime, which you all have to go through as a matter of course in any kind of investment strategy that you are going to build. Well, I would like to see that for this. Perhaps you can expand it beyond AIDS because of your experience in other health promotion programs within your companies. That is fine, too, to see that it fits within a broader concept that you have applied generally and now you have just forced it into that same mold in this case.

DR. LEE: Admiral Watkins, didn't you have a way of measuring productivity in the Navy in all your programs with those young people.

CHAIRMAN WATKINS: You had the same problem there. You had to use cost off-set data that came in from the remediation programs. You otherwise had to put in, for example, extending the length of training courses because of illiteracy, or people graduating from high school that couldn't push a knob. We have the problem in business and industry. We had to put large dollars into a health promotion and health education in our boot camps we never had before -- people who couldn't run a mile in less than 10 minutes, couldn't hang on a bar for a second, that kind of thing.

So, we had to install all those motivational regimes. We had to completely set up an entire peer group called career counselors to be able to counsel sailors, "Sailors helping sailors" kind of things, to pull them up out of the swamp of hopelessness. I mean, we were getting youth at risk at a high rate in the last decade. One-third of all the people coming in were non-high school graduates.

So, we had to build the social support structure, much as you have already built, and that is something we could cost out and we could demonstrate the cost effectiveness of prevention over remediation. Getting the peers on our side was the real winner, and that didn't take place until about five or six years ago. So, it was getting our own work force to be supportive of the program as readiness in the work force to do the job, raising their morale, their spirit, their hopes for something better, their self-esteem, was a big part of it. They had to be part of the solution.

So, this is what we really need on this -- some recommendations -- because I think you and the Chamber hold tremendous leverage on the nation and you can influence so much. You have the political clout. You have everything going. So, if that kind of leadership could be brought to bear on this in an increasing way, it seems to me that we would go a long way towards getting ourself healed on this epidemic.

MR. BECK: We will give you a helping hand.

CHAIRMAN WATKINS: All right.

MS. D'ANNA: An example within our company in terms of projecting cost was one of the single most effective ways of talking to CEOs within our company to begin to support the AIDS education and we also had to sell it to remote areas in California, who weren't as receptive to looking at the issue of AIDS. So, we have had some experience even trying to sell it within our company and developing those strategies based on that that proved to be successful.

CHAIRMAN WATKINS: Good. We are going to have one follow-up question from Dr. SerVaas and then we are going to have to close the session and get on to our site visit.

DR. SerVAAS: My question is to all of you on corporate America and in your corporations you mentioned other things in addition to AIDS. I wondered if you have used the cost effectiveness of mammography for your employees. One out of ten women will have breast cancer. It costs $5,000.00 if you catch a breast cancer early and maybe $60 or $80 thousand if you wait until it has spread and death follows and many, many years of illness.

Do any of you do that and, if not, I think that -- we have never failed to convince CEOs of the cost effectiveness of doing that for their employees when you explain how tragic it is to let them go. Do you do that in your companies?

DR. LAWTON: We certainly have developed those kinds of cost analysis for other health promotion efforts. I think one of the problems with the AIDS issue is it is hard to see how you may be able to avoid actually the cost of a person contracting the disease inasmuch as I don't think any of us are convinced yet that educational efforts really changes life style behavior as much as it has been able to be demonstrated with the gay community here.

I mean, it is certainly encouraging but I think the problem we are facing is that inasmuch as the heterosexual population doesn't seem to believe they really have a real risk for this disease, we are not, I think, as confident that we may be able to "avoid" a case from occurring with that population.

On the other hand, I think that it is very clear that we can have the cost savings that has been discussed earlier around case management and alternative health care in the community through outpatient treatment. So, I think that the problem is going to be to show somehow that there are perhaps ways to even avoid a case from occurring.

MS. WEAN: I can just say from the station's point of view we have yet to provide even free -- low cost, not free, mammographies to our employees and to sectors of the community that ordinarily, one, don't have the insurance to pay for it and, two, certainly don't have the income.

DR. SerVAAS: Thank you.

CHAIRMAN WATKINS: Thank you very much, panel members, for being with us today. We appreciate everything you are doing. You really are a role model for the nation. We are very appreciative of what KPIX has done not only here but nationwide. They have been an inspiration, I think, in the television industry to get the right message out and to keep it moving and their aggressive management, I think, has been seen by all of us as we have learned a great deal over the past five months.

We certainly appreciate what you all are doing in the business community to set the tone and the leadership that is so necessary out there. Thanks very much for coming. We will adjourn now until 9 o'clock tomorrow morning and we will continue with our site visit to the Shanti Project.

(Whereupon, at 3:37 p.m., the meeting was recessed, to reconvene at 9:00 a.m., the following morning.)