TRANSCRIPT OF PROCEEDINGS

NATIONAL COMMISSION ON

ACQUIRED IMMUNE DEFICIENCY SYNDROME

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NATIONAL COMMISSION ON AIDS

HEARINGS

VOLUME I

San Francisco Hilton Hotel
333 O'Farrell Street
San Fancisco, California

Thursday, May 16, 1991

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NATIONAL COMMISSION ON AIDS

HEARINGS

THURSDAY, MAY 16, 1991

VOLUME I

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

MEMBERS PRESENT:

DIANE AHRENS

SCOTT ALLEN

HONORABLE DICK CHENEY, by

MICHAEL R.PETERSEN, M.D.

HARLTON L. DALTON, ESQ.

HONORABLE EDWARD J. DERWINSKI by

CAMILLE BARRY, PH. D.

EUNICE DIAZ, M.S., M.P.H.

DONALD S. GOLDMAN, ESQ.

LARRY KESSLER

CHARLES KONIGSBERG, M.D., M.P.H.

BELINDA MASON

ooo

I N D E X

P R O C E E D I N G S

8:30 a.m.

WELCOME

HONORABLE ART AGNOS, MAYOR

CITY OF SAN FRANCISCO

Madam Chair, Member of the Commission:

I would like to express our appreciation to you and the staff of the National Commission on AIDS for holding these hearings in San Francisco.

San Francisco, by necessity, has had to be a city and a citizenry that set the pace in responding to the HIV epidemic. We had no choice because the pace was set by the progress of this epidemic itself.

During your hearings, you will lean from the lesbian and gay community of the pioneering and courageous work they did to inform the public and care for those in need. Those efforts, begun ten years ago, continue to be pioneering in reaching a new generation and those who have been outside the community itself.

While our city is recognized for the respect accorded to each community in a diverse city, it is also true that we have worked hard to create a strong consensus for the frank educational materials and posters meant to underscore the seriousness of this epidemic. The new consensus data also informs us that Asians and Pacific

Islanders are the largest community of color in our city. I believe the information that the Asian and Pacific Islander community groups can provide the Commission will be important to your mission and to our city.

In welcoming you today, I would like to personally bring to the attention of the Commission two steps now underway which I believe are important to your work.

Shortly, I will sign a newly-approved health insurance program for city employees. For the first time, it will permit eligibility for domestic partners of our city employees. As we took this step toward fairness, we recognized that there are some who are uncertain about the impact of HIV on insurance costs. We believe that our work goes a long way toward answering those issues. In fact, I might note to the Commission that Kaiser Permanente, the largest provider of health care to our city employees, proposed rates based on their belief that HIV would add no additional costs -- but that new pregnancy and infant health costs will be added because of heterosexual domestic partners.

Among those who reviewed our cost estimates is Dr. Robert Anderson, chair of the Economics Department of the University of California at Berkeley, and I would be pleased to forward his report to the Commission.

I want to underscore that one of the ongoing issues that all cities face is the cost of providing care for those without insurance. And step we can take to see that more people have access to insurance and health care ought to be welcomed, and in particular, ought to be part of a comprehensive approach to meeting this epidemic.

The second step we have taken follows a recommendation of the Mayor's Task Force on the HIV Epidemic which I appointed. One recommendation was that the city establish a Standards of Care Committee to recommend standards of practice in therapy. The committee was appointed and issued recommendations last winter. Those recommendations were forwarded to physicians throughout the city. They also became the basis for discussion between our Health Department and the California Department of Health Services as we urged them to add more treatments to the Medi-Cal formulary.

I am pleased to report that the California Department of Health Services is taking our recommendations very seriously, and appointed its own committee which includes many members of the San Francisco Standards of Care Committee. I am hopeful that the outcome will be the addition of new treatments, particularly for preventing pneumocystis pneumonia, which will be both cost-effective and less toxic for those who

use them.

This morning I am pleased to provide a copy of the recommendations of the Standards of Care Committee to you. This committee will continue to provide updated recommendations as needed.

Again, I believe that it is important that we keep as far forward as we can in seeing that the best available treatments reach those in need, and become part of standard medical practice with full reimbursements.

I appreciate very much the Commission's interest in our efforts and your presence in the city for these hearings.

Thank you.

DR. OSBORN: We are very pleased to be so nicely welcomed, and we look forward to receiving the materials that you mentioned. It could be an important part of our program.

MAYOR AGNOS: You're welcome.

DR. OSBORN: I want to make my opening remarks quite brief because we have an important set of witnesses to hear from today. Indeed, I will simply comment that I pass along the regrets of Dr. David Rogers, the vice-chairman of the Commission, who is briefly unwell, and I think is improving rapidly; but, on the other hand, can't be with us during these hearings and

sends his regrets.

There are a couple of other commissioners who have not been able to join us. I want to express welcome to Dr. Camille Barry, who is sitting in, representing the Department of Veterans Affairs. Erwin Krinik (phonetic) will be back with us tomorrow, but Dr. Barry is with us today.

We will be having a format in which we have, I hope, free-ranging discussion. Before I say more about that, let me ask Commissioner Kessler if he would like to make some remarks in opening?

MR. KESSLER: Thank you, Dr. Osborn.

My task this morning, I think, is to invite the commissioners to what I think is an historic hearing for us. We are particularly blessed this day to have not only few from San Francisco, but across the country, who can be called justly experts and pioneers in this sort of process of thinking, of exploring, of expanding not only the community consciousness, but also the commissioners and the country, so that we can get over one of the major hurdles that has led to the expansion of the delays that we may not be proud of.

So, I ask the commissioners, on behalf of the community-based organizations around the country, and with particular pride in the gay and lesbian community's

efforts, I welcome all of our testifiers, our guests, and I welcome the full participation of the Commission, as well.

DR. OSBORN: Thank you, Larry.

We are going to have a series of panels this morning, and we want the panelists, as collective group, to be participants. In order to provide degrees of focus, we're going to have people, as we do in this first setting already, join us at the table, that part of the table, when their specific panel is involved. Other panelists are sitting, however, along the side. I think the idea is that we will all get the benefit of all of your thoughts as we go, but with some focus.

The first panel talking to us will be in this order: Dr. Pepper Schwartz; Dr. David Lourea; and Dr. Reginald Fennell. Welcome, and we look forward to your remarks.

AMERICAN SOCIETY AND SEXUALITY

Reginald Fennell, Ph. D. David Lourea, Ed. D.

Pepper Schwartz, Ph. D.

DR. SCHWARTZ: Thank you.

The mandate I was given was to sort of lay some groundwork about sexuality in our society in five minutes. So, given that we all understand the task, I will say some remarks and hope that the things that

interest you most can be addressed and discussed in the rest of your meetings, as well.

When we talk about sexuality, we generally embarrass or threaten the vast majority of listeners. I'm not going to go into why this legacy of our Judeo-Christian past seems to have such tenacity. I won't, unless you ask me directly about it. But sufficed to say, right now, that it does. Not that you need a Judeo-Christian tradition of guilt, sin, and fear of women to suppress sex. Most totalitarian societies make sure they control sex. Because sex is really the mark of individualism. It is the thing that we do most personally, most privately, most ungoverned. And, to govern it is to govern human behavior.

In a society like ours, based on capitalism, achievement and discipline, sex is upsetting. First, it's a loss of discipline. It's proof of our animal natures; proof of our propensity to act, rather than think. It's a positive blot against our rationality. We have bodily functions and we fear them. We fear acknowledging them, we fear doing them. We fear doing them badly. We are disappointed in our bodies, fear of our fantasies, and usually without information or education to guide us.

Western culture has no sexual folk wisdom to pass among generations, unlike some. For example: A

friend of mine, who is a Plains Indian, tells coyote stories that are explicit sexual stories about what to do and what not to do, handed through generations. Most of the kind of conversations we have are abstract at best, misleading at worst, and often have technical terms like sort of "wash down there."

In particular, we hope to be adequate men and women, which is involved with our sexuality, and most men and women aren't sure that they reach adequacy. We have no tolerance for ambiguity, which life absolutely requires. This explains, I think, some of our most vehement feelings. We're all afraid of the feelings that disturb the social order. To love, we think is good; mostly, we think of it as leading to marriage in a heterosexual mind-set. But passion, which implies loss of control, is threatening. Seduction, which fits into the orderly evolution of society is good; but, sex, which may have some other purposes, is troubling.

Now, we are all reintroduced to the historic meaning of sex, which we wanted to forget: The linkage of sex with sex. Hard to accept for a generation born between 1945 and 1960. A generation in which syphilis was tamed and remediable. A generation whom sex meant freedom, adulthood, rule and role breaking. A generation of heterosexual women who demanded and got the right to

have sex without reproduction.

Homosexuality, it is true, by and large is not reproductive. That must refer the average person's reaction to sex, which is troubling; and passion, which is even more troubling. And now we're left with the specter of death, which is terrifying.

Bisexuality occurs not only with involved reaction; but, since it requires tolerance of ambiguity, it's often upsetting to both heterosexuals and homosexuals so that it's very existence has been denied. Longer, concrete categories in this society. It's the one homosexual act which heterosexuals need to classify for homosexual. That one heterosexual act, which homosexuals dismiss and describe themselves as bisexuals. It seems if one dropped the homosexuality in our society, it would be much more closer to correct to drop the heterosexuality.

All of this, of course, went to the few rather interesting time to calculate how many gay people are gay, and so on, in the midst of the other countries in any given year. And, I'm not going to take up my time to go on too much about the study. But, in fact, only random samples you get to look at are not in this country. They are in Great Britain, France, Scandinavia. And they really range quite dramatically from about 3 to 4 percent of the population to about 15 percent, everyone having

ever had a homosexual act.

This is just real fast, but just to remind you. It goes from 1 to 6, with 1 being completely heterosexual, with 1 being completely homosexual. But, you are in the 5, let's say, on the scale of homosexual, with slight heterosexual experience, the label you get is not behavioral. It's a label of an identity. So that we lose cognizance that there are people who are 5, or 2. But, rather we polarize their identity and we no longer keep track of their behavior. Moreover, those behaviors operate outside the perimeter. Moreover, we tend to not look at how people categorize themselves, and so we look for the way people behave.

Spanish male farm workers, approximately 50 percent of them were having sex with men, and no one of them was thought of as homosexual. Moreover, they certainly did not -- they used condoms and personal items with their wives, but certainly wouldn't produce it. That was, of course, okay when there was barriers between high-risk populations and low-risk populations. Those barriers have diminished, but those people do not see themselves at-risk because they are not being homosexual.

In a study I remember of Greek men, from a Greek community, one of my favorite quotes there was a Greek man who said, "We have three types of Greek men in

Greece: We have men -- I'm not going to use his actual words --

(Laughter.)

You will excuse the sanitization. You want to talk about this over coffee, we can do it differently.

He said, "We have men who penetrate men. We have men who penetrate women, and then we have queers."

And I said, "What do you mean?"

He says, "Well, the queers are the men who were penetrated." In his point of view, and in the view of this community, there was no such thing as homosexuality unless you were on the receiving end of penetration.

So, how we -- our meanings and our definitions and our behaviors and our identity, none of these things really link up, and, yet, we try and categorize nice, neat categories because they help us count, they help us define, and, so some extent, they help us put away the reality of human sexuality out of our ken. Rather conveniently, however, we drop this idea of sexual essences, that people are really only one thing only, when we are figuring out legal and policy approaches to dealing with our prejudices. Are homosexuals born and not made? Then, let them live their lives in peace, since no one is, quote, unquote, "at risk." But, if they are made

and not born, then, let's assume there is a continuum of sexual preference out there, and we really have a great many different kinds of desires and possibilities within us. That scene is usually rejected and threatening; and, yet, we base policy as if it were true.

What is the real continuum of behaviors? I'm here to tell you what you probably know: We have an inadequate data on almost all of those kinds of questions. Anything I give you is tentative and in process. The best statistics we have, the best studies we have, are on teenage sexuality and fertility. Why? Because we are interested in family. We're interested in reproduction. We're interested in the control of fertility. When you want to talk about sexual statistics that have nothing to do with fertility, we get much less wonderful studies. They are less national; they are less random; they are less highly funded.

I actually had some statistics here about age of intercourse for young people. I am going to skip it. I think my colleague to the left is going to talk some about that.

What I can give you and what I'm again going to pull for a moment -- because I don't want to go on too long -- are a little bit of the studies about what kinds of people are having sex, how often and with whom, from

smaller studies, nonrandom studies. But, I will be glad to answer questions about that, if this is something you'd like to go into.

I think germane to the interest of this committee, however, is to what extent homosexual and heterosexual people cross over and have sex with each other; to what extent sex goes outside of a closed loop of monogamous relationships so that, to some extent, disease dissemination is most likely. And, again, we have untrustworthy data; but, in a nutshell, I will tell what I think we know.

Most people, the general average heterosexual in this society has maybe three or four partners before marriage. That's the general. We always have people who are doing more than their share. There has been some very interesting epidemiological studies to show that there are often sort of sociometric stars, that is: people who have sex with a great many people so that, on one person's category, who has three or four sex partners in their life, this person is likely to show up. And that person, however, is atypical and has had hundreds of sexual partners. What that person's health status is, of course, is extremely important. They do more than their share in a number of ways.

The number of people who have sex out of

wedlock, among heterosexuals, is one of those statistics that is extremely unreliable. We have a number of studies. There is a study by Andy Greeley that was a random study done through the aegis of a magazine, but it was a random study, where he comes up with only about 10 percent nonmarital sexuality. On the other hand, most studies have come up with something more like 25 to 30 percent. So, take it for what it's worth.

A recent Kinsey Institute, looking at gay people, showed about two-thirds of homosexual men have had sex with a woman; about one-third have been married sometime in their life; three-fourths have had at least one encounter with a married man; 20 percent of lesbians have been previously married. And, in a study of over a thousand lesbians in four major cities, 50 percent have had at least one new male sex partner, since 1980. And there is a more than average chance that sex partner will be a gay male.

So, there is a lot of sex going on. We try and recognize some of it. We don't like to look at other parts of it, depending on how it fits our national norms. And being naive in having watched the politics of birth control nationally and internationally, sex education and AIDS education, it therefore does not pay for me to be too aggressive in my recommendations; nonetheless, consider

this:

Without sex education, there is haphazard contraception, and there is no assurance of instruction in health behaviors. With education, we have seen somewhat more use of condoms, slower entrance into sex. With recognizing sex, and address the consequences, and without being clear about the diversity, continuum, and the ability of sexual behavior, we can't hope to have a proper study of people. And without acknowledging our passionate and sometimes foolhardy nature, we cannot give a pragmatic approach to sexuality. And the refusal to deal with reality, we can't and often don't state an outcome, especially now, especially because of AIDS.

DR. OSBORN: Thank you, Dr. Schwartz.

Our request for our panelists to be brief is not because we don't think we could learn a great deal more, if we could hear from them longer; but, rather, so that we can get a chance to interact. We appreciate your willingness to live with that constraint.

Dr. Lourea.

DR. LOUREA: Thank you.

In 1975, when I decided to pursue a doctorate degree in sexology, I assured my family that one of the benefits of being a doctor in the field of human sexuality is that sex is never a life and death event, and

never an emergency; and no one is ever likely to call me at 3:00 a.m. in the middle of a crisis situation. Regrettably, today, the choices we make concerning our sexual options often do involve life and death decisions. And, on more than a few occasions, I have needed to respond to anxiety calls in the middle of the night.

In order to understand the role sexuality plays in American society, it is important to remember that, until the 1930s, sexual information on human sexuality was locked behind the closed doors of libraries because it was deemed unfit reading for the general public. Only medical doctors had access to the research that was available.

It is generally conceded that modern sex education began in the 1930s when a group of students at the University of Indiana protested the moralistic attitudes that kept knowledge unavailable to them and demanded a course on the nature and understanding of human sexual functioning. The powers that be at the University of Indiana tried to figure out how they could give the students what they wanted without giving them what they wanted. They decided to offer several lectures on the biological aspects of sex and marriage, but had a few qualifications for the person who would give those lectures. First of all, he had to be an empirical

scientist, whose methodology was impeccable. Second, his personal behavior and moral standing in the community had to be unblemished and beyond reproach. And last and most important, he had to be a dull and uninteresting speaker, so as not to in any way arouse the passions of the students.

The professor they chose was a zoologist, who had classified over 500 species of gold wasps. The gold wasps are insects that reproduce asexually. He was one of the first ten Eagle Scouts in the United States, and we know that their moral fiber is upstanding and beyond reproach. And he was not a very dynamic speaker. His name, of course, was Alfred Kinsey.

Turing to the professional publications in the field, he discovered that most of the information was highly speculative and based on inadequate statistical samples. The available literature could not answer some of the simplest questions put to him by his students. No one had ever actually sat down and asked people what it is they do sexually. Kinsey, therefore, realized the need for a major new study on human sexuality. The results of that study, Sexual Behavior in the Human Male, published in 1948, and Sexual Behavior in the Human Female, published in 1953, marked the true beginnings of the movement for sexual freedom. Although it created a great

deal of controversy, it showed people that their sexual actions were not unique; that, what they did sexually, was also being done by others.

One of the important movements to influence the sex field was the humanistic psychological movement, which suggested that people have as much right to feel as they do to think. The Civil Rights Movement, the Feminist Movement, The Gay Liberation Movement has profound effect on the relationships between the same people, and had one thing in common: a strong desire to see all persons treated as equals, with the right to feel good about themselves and to live lifestyles which best suit them without societal interference.

Another push to the sex field came with publication of Human Sexual Response in 1966, and Human Sexual Inadequacy in 1970, by Dr. William Masters and Virginia Johnson. This historic book, based on the physiology of sexual response, did much to bring sex to the attention of the medical community. While Kinsey added to our knowledge of what people actually do sexually, the Masters and Johnson showed us what actually happens on a physiological level.

The National Sex Forum was created in 1968 to look at how people actually feel in relation to their sexuality. What they discovered was that most of the sex

problems difficulties and disappointments in people's lives are a result of a lack of accurate information, accurate nonjudgmental sex-positive information, and faulty attitudes and value structures. They developed a sexual attitude restructuring process, designed for educating adults about what people do sexually and how they feel about it. Some of the assumptions they made were: sex is managed today better than ever before in history; that there is a growing belief that human sexuality is potentially positive, joyous and an enriching experience, as it relates to individuals making commitments to their own sexuality, to their sociosexuality, and to the sexuality as part of life.

With the concept of human sexuality, as potentially good, comes the growing conviction that there should be some programmatic forms of sex education. The immediate problems of sex education are: (1) Who will teach that?; (2) What will be taught?; and How will that be taught?

Who will teach sexuality? The socially accepted educators in the past have been parents, schools, churches, and doctors. What was basically being taught fell into two major categories: (1) reproductive biology, via marriage manuals, doctors, schools, and school health science courses; and, (2) the management of social

relationships, social etiquette, via marriage manuals, school family life courses, church relationship literature, and newspaper good advice columns.

Some of the problems of the present approach was that reproductive biology represents something that merely happens, rather than something that is experienced or thought about; and, that it misrepresents the pleasures and meanings sex. Most of the time, people do not have sexual intercourse strictly for procreation. The problem with management of social relationships have been that it often becomes misinformed good advice, and often doesn't take into account individual differences.

The most significant factor in sex education is that sex can be talked about not clinically, but casually and nonjudgmentally. If I am talking about intervaginal containment, and you were using more explicit language, we are not communicating. Individuals should be allowed meaningful exposure to the realistic objectification of the range of behavior into which their own experiences, and those of other humans, fall. Appropriate topics are: What humans actually do do, and how they feel about it. People who teach, counsel, must have a low version of sexual guilt feelings so as to be of service to those whom they teach, counsel or give advice, and not serving their own needs.

If there is mistrust from sexual minorities towards the traditional sources of sexual information, it is important to keep in mind that those of us whose sexuality does not fall into the narrow moralistic confines of that which is currently socially accepted, we have a long history of being ashamed, abused and persecuted (1), by the state, who has labeled our sexuality criminal and illegal; by the church that has condemned us as sinful and immoral; by the psychiatric profession that has pronounced us mental ill, immature, or insane; and by the medical profession that has related to us, either verbally or nonverbally, as unhealthy and diseased. To counteract this distrust, it is important that safer sex instructors understand that sex plays a very important in each person's life; that sexual fantasies, desires, dreams, should be recognized as a valuable and integral parts of each person's sexuality; that sex can and should be discussed casually and nonjudgmentally.

Individuals can enrich their own sex lives by learning about the full range of sexual behavior. Individuals have the right to all the facts. Everyone has the right to a good sex life, including those persons who have physical disabilities, such as paraplegics, diabetics, amputees, heart patients, those of us with HIV

disease, or mental or emotional problems. Sexuality is the most individualistic part of a person's life. It is up to each individual to determine, and then to assume responsibility, for her or his own sexuality. All the varying modes of expression are available to everyone, as long as most people know what they are doing and feel good about it and don't harm others.

To experience a healthy and fulfilling sex life, we need to learn about and appreciate our own bodies, know our feelings and our own sexual responses, become sensitive to the physical and emotional needs of others, and to develop meaningful, intimate contacts in our sexual relationships.

Thank you.

DR. OSBORN: Thank you, Dr. Lourea.

Dr. Fennell.

DR. FENNELL: Thank you.

When I think about knowledge and attitudes and sexuality, I am going to specifically make my remarks in reference to the college population, since I'm a college professor. I am going to try to do them within that context, although I will talk some about what's happening with the American teenagers.

As a professor, if I had to assign a grade for sexuality and knowledge, or knowledge of sexuality to

college students -- and this is looking at other studies and also the work that I've been doing -- I would probably give them a grade of a D-plus. That may be a minus. My students tell me I'm not nice --

(Laughter.)

-- and I probably would just give them a grade of an F, which is unfortunate. The president of Planned Parenthood, in her writings, has said that American teems are sexually active, but sexually illiterate. I think that almost sums it up, and I would end there; but, since I have this time, I won't do that.

(Laughter.)

In addition, there have been several studies that have pointed out that college students are still found failing to take precautions against HIV infection because of their immortality complex, or the feeling that it can't happen to me. In 1991, this is still going on, despite all the efforts that many of us in this room have undertaken.

What I want to do is to mention some of the -- highlight some of the statistics that have been compiled by the Center for Population Options, that talks about sexuality in America.

It's been said, or it's been found that the average young woman has engaged in sexual intercourse by

the age of 16.2. The average for a young men is 15.7. Now, if we were to look at inner city youth, that average is even much younger than that. For a Black or African-American teen, being about 11.8 years in some inner cities. In addition to that, usually the decision to have sex is a spontaneous one for young Americans. It is not something that is planned. About 17 percent of women and 25 percent of young men, in fact, don't even plan their first act of sexual intercourse. About one in six -- and my students always act so surprised when I say these kinds of things. About one in six high school girls, according to these studies that have been compiled from the Center for Population Options, about one in six high school girls have had at least four different encounters. That is high school. In each year, about one in six teenagers contracts a sexually-transmitted disease. Then, there are other studies, too, that have shown that, in most -- although there is a small percentage of people that are using contraception, in many of those cases, that choice is not the use of condoms.

One of the things that I've been doing, since 1987, on the college campus where I am working, is, that, I've been teaching a credit course on HIV infection and AIDS, mainly on the education and prevention. It is still interesting that, since I've been doing that since

1987, and prior to that I taught human sexuality for a couple of years, it is still interesting to walk into a classroom at the beginning of the semester -- we could even take this one -- and find that I still have to go through a lot of the myths and misconceptions that students have about HIV infection. I was explaining to my colleagues right before we started that not as many, but I still find myself having to try to look at the myths and misconceptions that students have about, for example, the fact that you cannot contract HIV infections from swimming pools.

Some work has been done by the American School Health Association, which stated that about -- these numbers, I think, change -- but only about 25 school require health education for high school graduation; and about the same number -- although I think it has increased some -- require HIV education for graduation.

So, what I find on college campuses around the country is, that, the majority of students, who are matriculating to college campuses, still have not had an HIV education. So, there is a great need for it at the college campus.

Some work that was done by the American College Health Association, with a cooperative agreement from the Centers for Disease Control -- and perhaps many

of us have heard this -- they tested anonymous blood samples from 19 different college campuses and found that 2 per 1,000 of these blood samples were HIV infected. That study is being repeated now on other campuses. We don't know if we can generalize that data or not. But, if we could, what it would potentially mean is: 2 per 1,000 students, on any given college campus -- and it may be higher in some areas than others -- could be HIV infected.

We have all heard other statistics, too, about the number of teenage pregnancies that occur each year, and the number of those that are unintended. With that kind of information, my question is: How do we reach people who say to me, and who say to us, that, well, this isn't something that happens to me; it is something that happens to people from lower-class neighborhoods, or it happens to minority groups, or it happens to gays and lesbians, or to gays? And unfortunately, those kinds of comments are still being said. However, when we look at the STD rate, we know that students are definitely at-risk for HIV infection.

How do we reach these students? I mean, that's a question that I think that many of us are wrestling with. How do we get these students to understand that they actually are at-risk when there have been several -- although they are nonrandom studies; but

there have been several studies, some of which have been mentioned here so far this morning.

Well, one that I always like to highlight to my students is: one of the things that sometimes we give out as educators, and I try not to do this unless I qualify it anymore, is: We say to people to get to know your partners better. Well, know, we're getting into euphemisms. Because, for some college students, that may mean, well, go out on two or three dates instead of having sex after the first date. And, then, even after we told them to get to know their partners better, what does that really mean?

There is the work that came from Cochran and Mays that looked at dishonesty in dating. And, in the study that they had, it was 422 sexually-active college students. And, 34 percent of the men and 10 percent of the women admitted to telling a lie in order to have sex. Those are the ones that admitted to telling a lie. And, then, 68 percent of the men, and 59 percent of the women, said that, even though they were involved with one person, they didn't tell that person they were having sex with that they were also, at the same time, having sex with another person.

So, getting to know your partner better, what does that really mean?

One other point from that study, and I always highlight this with my students, too, is: 20 percent of the men, 20 percent, and 4 percent of the women, say that they would lie about their HIV antibody status, if they were asked.

And then, one other study that I want to highlight -- I don't want to sound too academic -- is from the Kinsey Institute. These would differ a little from what other sources said in terms of number of partners. They did a study, a nonrandom sample of over 800 students, and they found that, on the average from this sample, the average number of lifetime partners for college females was six, with three one-night stands. The average number of college lifetime partners for the college male was eleven partners, with five one-night stands. One of the things that also was highlighted in this, which is good for me to stress, since I'm from what some would consider the Midwest, being in Ohio, to quote from this study. I always like to quote this, being from Ohio, when I'm talking -- particularly if I am in the areas of the country that are in the Midwest. The quote from this study from the Kinsey Institute said: Heterosexual college students, even in the Midwest, have unprotected vaginal and anal intercourse with several partners. Even in the Midwest, we do have sex in the Midwest.

(Laughter.)

In addition to this, this isn't -- and some of the points that are being made here, I think will be made throughout the next two days, is not looking at the fact that, on college campuses, we do have diverse populations in terms of sexual orientation. So, in terms of what kinds of things I think perhaps need to come out of this, or that needs to be done, are actually six or seven things that I think should be looked at specifically. I say these in terms of recommendations, but these are certainly up for discussion, which is why we are here this morning.

One of the first ones I would say is: Given the fact that many of the students who matriculate onto college campuses have not had health education or HIV education before they graduated from high school, I think something needs to be done to suggest strongly to institutions of higher education that they have trained individuals -- and I probably have a bias, since I'm a health educator; and that has to be taken in that context -- that they have trained health educators who can provide sexual health information to students. There are certainly some excellent examples around the country where institutions have done this, such as Dr. Richard Keenan at the University of Virginia, in their Student Health

Center, with peer educators and individuals who are hired to do sexual health education. That would be one of those: to have trained individuals on the campuses who can provide sexual health information.

Another one, which still evokes a lot of controversy -- and I even know this from my campus this semester -- and that is: To recommend that colleges and universities make condoms accessible in the least restrictive and nonthreatening manner. They need to be accessible in a least restrictive and nonthreatening manner.

One of the studies from JAMA, that was just out last year, said: some of the factors that were associated with not using condoms included embarrassment over discussing them with partners. Since this still is a factor, there has to be something to create a standard or norm among young people that, if you're going to have sex, this becomes a norm or a standard, so that we can get rid of some of that embarrassment.

Another one that I would suggest would be that colleges and universities need to recognize that campuses do have diverse students, and that not all of the students on campuses are heterosexual, and that there are gay, lesbian and bisexual students on the campus who do have needs. There should be individuals who are trained

to provide counseling and other services to those students. I think an excellent example of that is, that, last year, Ohio State University actually established an office of gay, lesbian and bisexual services. Although they received a lot of flack from some individuals about having established that office, they said they will remain strongfast and maintain that office. It's much like a lot of campuses have set up offices for African-American students or for Hispanic or Latino students, and for women services. So, I think they are one of the first campuses in the country to actually establish an office for gay, lesbian and bisexual students. I think there is need for other campuses to consider doing services such as that.

I think one of the things that seems to be the hardest thing to do that I think needs to be done is: I think we have to recognize, the colleges and universities need to recognize, that students do have diverse values, and that we need to teach students to respect themselves and others. I think that is starkly different from teaching morals. Somehow, we need to make sure that we make that that difference is known in terms of not -- we aren't trying to teach people more, but we are trying to teach them values and respect for each other.

One of the things that I think needs to be

done more of, and that is: college and universities I think need to come up with strategies, or innovative strategies, to make the consequences of unprotected sex real to college students. I think, for too long, in higher education, also in secondary education, it's been this passive learning process where someone sits, someone stands before a group of students, lined up in rows, and tells them different information that they want them to have. The students are, then, supposed to memorize this and spit it back on a test. Well, I think that has to change when it comes to, when we're talking about health behavior, and particularly about behavior change. I always like to use the adage, at least in what I do, is: What I hear, I forget; what I see, I remember; and what I do, I learn. So, some of the studies that are coming out are saying that, what seems to have the most effect in terms of reaching of people is when we are using peer education, when we are using theatre groups, when we are using humor.

One of the things that I've been known for, at least on my campus and in some of the presentations that I've done when I've had a chance to go around the country, is: I use a lot of humor when I do presentations. I think some studies have actually shown that these can be effective. Humor is used because

studies are saying that people are, college students are embarrassed to discuss these issues and to even say the word "sex." It usually comes out as the word "it."

So, when I do my presentations, I'm known for using as lot of props, so even here, I had to bring props. Some of the things I deal in involve giving my students -- and I know this embarrasses some people and it offends people; but I even say to them that, if your HIV education program is not controversial and if it's not offending anyone, then, it's probably no good. I mean, if we can sit in a room and discuss sexuality and someone isn't offended, then, I would question that program. Maybe in the year 2000 or 3000 it might happen.

So, one of the things that I do is, is I give out different kinds of condoms. I mean, this some of the many students haven't heard of, and this is a mint-flavored one. It always gets their curiosity up, wanting to know why is it mint flavored? We talk about that later. If people want to ask questions, I'll answer that later.

(Laughter.)

Another thing that has happened, too, as a result of some of the things I do is: controversy certainly has surrounded me and the kind of work that I've done. Fortunately, for me, and this won't be the case

for all educators, that's why I think recommendations are important when they go to colleges and universities and say these kinds of things need to be done, and these are the kinds of things that colleges and universities should be doing. Fortunately, for me, probably like my colleagues, my work is being published. I get a chance to go around the county and speak. But some professors, who may be trying to do these kinds of things, won't have that kind of support to affirm the kind of work that they're doing. That's why I think, sometimes, mandates or recommendations can be helpful. I think this education really needs to go to being comprehensive health education. Not just sexuality education. I mean, I think it's a well-known fact that, quite often, when young people are engaging in sexual behavior, or sexual intercourse, alcohol has been present. Which means now we have to talk about regretted sex. We have to discuss acquaintance rape, and rape and other issues. Because all of those are interconnected. So, it can't just be an HIV education program. It has to be a comprehensive health program.

The last two things that I think are important, too, is: despite all of these things, even with the things that I do that use humor, there has to be some kind of evaluation mechanism in place that documents

the effectiveness of these programs that we are putting money into so that, if they are effective, then they can be replicated by other campuses and other placed in the country. And these programs -- this seems like a real simple point, but it seems to be one that gets missed all the time, and that is: these programs need to be developed with and by students, or with and by the target population. Quite often, when I've been asked to go to different campuses and consult, it always surprises me that people are -- especially in a budget crisis -- someone wants to bring me to their campus and tell them how they can reach their students, and we have a meeting and there are no students there, these programs need to involve their target group and the students need to be involved in the planning of the program and in helping to implement the program if they are going to be effective. I think it is a crucial point, but it's one that's looked over all the time.

Thank you.

DR. OSBORN: Thank you very much, Dr. Fennell.

I would ask Larry if he would be willing to facilitate the discussion. Larry, I will turn it over to you.

MR. KESSLER: Since this is a time for the

commissioners to ask questions and be involved, and we have approximately 40 minutes, I would yield first to the commissioners; but, then, I would like to have our guests involved in this discussion, as well.

Before going to the Commission, I would like to invite of the three of you to comment on, if you have any comments and reflections on the presentations by your counterparts. If you felt there was something, a theme here that struck you that you would like to elaborate on, feel free.

DR. SCHWARTZ: Well, one comment, comparing college students to everybody else, they are more sexually active than some of the rest of the population because they have such an easy pool of eligible, a lot of sexuality opportunities, and college is a great place for opportunity. But, what I would want to emphasize from my colleagues remarks here is, that, most of the things he said about college students can be said about most people, vis-a-vis, their preparedness for sexual behavior, both their level of knowledge, their level of ability to protect themselves, their impulsivity, their spontaneity, and their bad information. I'll just give you one anecdote of a woman's group that was I was interviewing:

These women were all between 40 and 50. Half were married, half were single; half were talking

about their sexual adventures of the week before. None of these women were sexually active all the time. They had recently, about four of them, had had the opportunity to become sexually involved with someone. And all of them had brought condoms to this situation. None of them had ended up using them. All of the men had said: "What kind of guy do you think I am?" All of the women had backed down. None of the condoms were used.

I think we often concentrate on college students. And, in fact, that is often a good indicator of things that are and aren't happening elsewhere.

MR. KESSLER: Dr. Lourea?

DR. LOUREA: Picking up on that same point, I was interviewed by a radio station, TV station, in Sacramento. They wanted to know what women needed to know about men and men's sexuality to determine whether the men were bisexual or IV drug users so that they could make decisions. One of the things I told them, and this just not true for men, but one of the things I told them is: What women need to know about men is that we are liars. We have been lying to you for thousands of years, if we thought there was the opportunity that we could be sexual with you. We will tell you that we love you. We will tell you that you are the only one. We will tell you that we are not HIV-positive. We will tell that we have never

had sex with anyone else except you, and the check is in the mail.

It is incumbent on all of us to develop the attitude that we are each individually responsible for our own sexuality. There is -- that we cannot base the life and death decision, which we may make, on someone else's honesty.

One of the points that Pepper made that is extremely important is: We also can't judge by someone else's label our safety. A number of lesbian women assume, since their partners are lesbians and they are very positive of that, that they are therefore at no risk. Because they are so adamant that their partners are lesbians, they do not give their partners the opportunity to tell them that, in fact, a great number of lesbian women do have, frequently or occasionally, and frequently regularly, sex with men. A number of gay-identified men have occasional and frequent sex with women. Someone's label does not necessarily tell you what their sexual behavior is like.

MR. KESSLER: Mr. Dalton.

MR. DALTON: First, first up on the point of labeling. Obviously, one of the take-home messages is to focus on what people do and how they feel about it. Labels can often can strain the mind. It reminds me of a

story, I guess, that Havelock Ellis tells, about a Victorian woman, a crusader, a leader in the sexual purity movement; and, in particular, in the movement against masturbation.

One day, as she was handing out pamphlets against the solitary vice, as it was sometimes called, she happened to glance down and read one of these pamphlets and read what the behavior was, and realized that it was a behavior that she frequently engaged in herself. She basically freaked out, was unable to -- I mean, had a breakdown because of the inability to conform her label and her beliefs with, in fact, her own behavior and desires. There is a lesson there for all of us.

I have a couple of questions. I'm going to sort of go back to Dr. Schwartz, some of the stuff that she said about sexual essences. A quite interesting discussion about our tendency to want to put people into one kind of sexual box, if I can use that, in spite of all that we know. And, in fact, in your discussion of how a little bit of homosexuality seems to somehow, from both the straight side and the gay side, put one in that camp. I was reminded of the one drop of blood rule, with respect to race, makes you black. And I think there are some very similar kind of social dynamics going on.

But, as you pointed out, one of the things

that keeps, that keeps knowledgeable people wanting to line people up in -- that is, treating people as if sexuality is essential, natural and unchanging is the law. Because, what you sort of admit otherwise, that, in some ways, you give policy makers license to try to change people. That is, if we prohibit sodomy, then, that may sort of force gay people to becoming straight. That is one.

So, how do we sort of -- how do we talk honestly about the variability and nonessentiality of sex; and, at the same time, not give aid and comfort to people who would try to constrain a sexual minority? That's one question.

The other question -- question? -- has to do with this notion of trying to develop norms of sexual behavior, as Dr. Fennell said. One way to do it is through, I suppose, sex education, sex educators. One way that we do do it in our society is, again, through the law, through the criminal law. Part of what is going on, when we create laws that say, if you have -- if you are HIV-positive and you have sex, that's a crime. Or, if you have HIV-positive, you are HIV-positive and you don't tell somebody and you have sex, it is a crime, or we let somebody bring a cause of action.

Part of what we're trying to do is to

construct a code of conduct around sexuality. Trying to decide what is the right way to behave to one another; what is the wrong way. When can you lie? When can you not lie? In the age of sex -- in the age of AIDS, rather, what is the proper way for one person to relate to another. I happen to think the criminal law is a pretty poor way to go about doing this. What is a better way? How is it that in the age of AIDS, when we can't even talk about sex -- or, if you can, it's easier to talk about it in public than in private -- how do we develop kind of a set of norms about how people should relate to one another?

DR. SCHWARTZ: Gee, those are good questions.

(Laughter.)

I'll respond, little that I know. You will probably want to respond, as well. Probably you will, as well.

There has been, and you are probably aware of it, both an intellectual and political controversy about how to define sexuality in terms of the outcome which would come in law and policy from it. There are a number of researchers that do believe in sexual essences. They try and use cross-cultural material to show that gay is gay is gay across countries and across history, and why

not just accept that certain percentage of happenstance and let people live their lives. I think there is some evidence -- I am willing to believe that there is some percentage of deterministic sexuality. You know, we don't -- we haven't been able to find it yet in terms of chromosomes or hormones, or whatever; but I'm not prepared to say we know everything we need to know. There are some continuities that say that, perhaps, there is a percentage of people that this is in the genes somewhere.

But, what one can say is, regardless of that, people don't sign up one day. However we become homosexual or heterosexual, we are not always the masters of our own universe. And we find ourselves responding to stimuli not because we have made choices, but because choices seem to be coming into our sphere and we notice things in a way that we don't control. In the same way the majority of us have had heterosexual socialization of our own sort because of who we notice and what experiences we had, we didn't predesign that and decide that would be the easiest and best thing to be. So that, in a sense, it's almost besides the point, how we become homosexual or heterosexual -- and God knows! We don't understand how we become heterosexual, much less the other; but we know it's a complex and nonvoluntary volitional process.

So, therefore, we don't need to fall in the

trap of whether it is an essence or not. But rather that people are what they are, and they become it in complex ways we cannot control, nor will be ever finitely understand. So, that, in order to make policy about people, as if they did in fact design their own sexuality, is against almost any theory out there that any one accepts in any major way. It would be as if we constrained.

If we told a heterosexual: Okay, now we're going to decide what behaviors you will do and who you will do it with, and who you will find attractive. We simply couldn't. It wouldn't work. It would be punitive. It would cruel and unusual punishment.

I think those arguments could be made more fulsomely than I will here.

So, the issue then is: I think there is a base for policy that is respectful of human difference, the variety of sexual experience and sexual identity and sexual behavior that will occur through the life cycle. and, to account for it in terms of the kinds of sex education and information and policy that we make. That, of course, is in the best of all possible worlds. In reality, it's a very strong lobby that is scared silly of just that approach, and it interferes with all rational reactions to not only AIDS, but all other kinds of

sexually-transmitted diseases and all kinds of fertility and other kinds of instruction. And I believe it just has to be met with intellectual and political force, to say, "Here are the realities of this untrue opposing viewpoint of trying to stricture human life and human behaviors into a model that simply doesn't fit anybody's knowledge of reality, or anybody's sense of popular beliefs are changing. It is fooled, and wrong, and untimely. The balance of the actions has just got to be -- that's relevant. It has to be public education so we have the public protected and have their own wishes and desired promulgated.

I think that these arguments are very powerful, and that we can do social policy based on reality, as opposed to social problems on what I believe is actually, ultimately a minority point of view, when you finally get down to, you know, its core proponents. So, that -- I could go on with that, but that's sort of what I think. I don't think we have to be caught in that it's either all natural and there's no possibility in our own sexuality for flexibility, et cetera. The important thing is that's it is something that is designed, ordered, controlled and dictated, no. That's the important issue.

As far as values go, and I will defer to Dr. Fennell on this. Because I've talked for awhile on this,

but also because I think he's been working in the trenches on this day by day by day. Just my own general feeling is, again -- you are talking about these small, piddling, ineffectual educational information that we've been doing, this band aid stuff that makes us feel good and does nothing society-wide, but a much larger discussion of our responsibilities to each other as human beings. This is, I think, you know, has to permeate society and male and female relationships. I think we are actually on the right road in the sense that I think men and women, while in a real world, of course we are not honest nor are we just in the ways we should; nonetheless, there are norms of behavior. We do, in fact, construct norms of behavior. We have certain civilized conducts which, at least when we violate them, we know we have. Now it is not entirely clear what are violations of civilized behavior, vis-a-vis, sexuality. We don't even know the outlines of what our conduct should be.

So, I think the idea is right, but it's nothing that will happen unless we are talking about a whole different emphasis, economically funded differently, and placed differently so that my colleague, here, isn't one of a few valiant souls doing model programs in isolated places.

DR. FENNELL: I think this comment about

having laws that says it is against the law to have sex if you know you are HIV infected and not telling your partner is just that: it is a law. But it doesn't speak to the issue that -- I mean, many students are engaging in what we call serial monogamy, where this semester I might date Dr. Osborn, only have sex with her, break up; next semester, I date Mr. Allen and only have sex with him. So, even that, I mean, how would you even go back and determine how I contracted that, given the number of partners that not only students, but society at-large might be having?

Trying to create norms I think is the way to go, to try to get us just to be able to talk, I mean, as a society about these issues. That is why I think a commission, such as yourself, is important because it is a national commission, it is established by Congress and the President, that could say: these are the kinds of things that need to be going on on college campuses or in society, which would give universities some place they could look up to and say: Okay, these are the standards, these are the kinds of things that we should be doing, as opposed to an educator, like myself, or others, who have to be concerned about their job security and who is willing to take those risks. I'm willing to take those risks.

As I said before, my work -- I'm in a good position, that I can take those risks. I've taken several this semester in that, on my campus, unfortunately, we are having the debate about how to make condoms accessible. I'm from a university that is known as a "public ivy." It is where the good students go to school, and our students don't engage in certain behaviors, from the administration's point of view. But, in fact, we are dealing with the same kinds of issues where, I mean, I've been under fire. But I also do volunteer work with people living with AIDS, and I know what that's like. I do what I do because I don't want to see my students going through what I see those people going through, as they are living with this infection. So, I'm willing to put my own job on the line to that. Fortunately, I have things that have protected me from having to risk my own job.

But I think we do have to create a norm. I think the Commission is in a position where they can say: these are the standards that a university should be working towards.

MR. KESSLER: Other commissioners? Ahrens?

MS. AHRENS: I have been real intrigued by Dr. Schwartz's address in the use of the terms ---

MR. KESSLER: Can you speak into the mic, please?

DR. OSBORN: I think it is on, you just have to lean into it.

MS. AHRENS: In terms of the phrase, "responsibilities to each other," it seems to me that, when we get into this conversation of sexual intimacy, it always seems to be directed toward or with or between the two people involved. It does seem to me that this is such a complex and enormous cultural issue, that, just to talk about the two people involved is to really miss the big picture.

It seems to me that it is not just an individualistic sort of decision because what is involved does effect, or can effect, certainly, other people. Even thought much of this activity, at least perhaps the frequency of it, is engaged in by very young people that do not have family kinds of responsibilities. That's the time when the teaching goes on, and you talk about the effects of this mental health, emotional, with not just with each other, but with those that are in a family situation. You can define "family" anyway that you want to. So, you're afraid your responsibilities to each other seems to me to be -- to put this whole issue in a much broader context.

As we look at how we address, as a Commission, this issue, and particularly the prevention

side of it, I think we have to be very specific in terms of the issue of HIV infection and it's transmission, and so forth. But, it seems to me to be important that we also be very broad in terms of the nature of the dynamic here that we are talking about, with respect to, quote, the entire family focus of the issue of sexual intimacy and it's function in society and it's relationship. Otherwise, it strikes me that we somehow sort of miss the big picture. I think the churches have been in for a lot of criticism here, much of it justified; but the emphasis that the religious community has always placed on a faithfulness has a dimension that is very important to the stability of society and the family, as it grows, and however you define family in society.

I was just intrigued by your phrase, "responsibility to each other." Because, it seems to me, that perhaps it is in that context that everything else should take place.

I wonder if you would have a comment about that?

DR. SCHWARTZ: Well, again, they are such big issues, and one is always just -- I keep having the same image, like people keep putting up mountains and say: Okay. Could you please walk up this mountain? It's such a large topic that each comment brings up.

I am social scientist, and I tend to deal with what is, as opposed to what should be. People come to their disciplines for different reasons. Mine is because I like to find out what is, and say what I think the possibilities are of what could be, within what I know about human behavior and human potential and human reality.

I think it is important for social institutions to say what they think should be. I also think that there are certain things about human behavior that seems to have some continuity over many cultures and many points in history. So that, while faithfulness would be, indeed, an appropriate why. In many ways, the warning point of view and weight of behavior at this point in history, and many others. On the other hand, one has to take into account that it is certainly not universal; it will never be universal. We have to have a policy that understands that.

In a study I did, for example, I looked at the extramarital behavior of people who were religious an nonreligious. By "religious, I meant -- it was defined as going to church or synagogue at least once a week. There was no difference between the highly religious and the nonreligious. But the highly religious thought it was worse. So they had more guilt, but they had similar

behaviors.

I believe that we need to tell people what we think will be in their best interest. And there has, in fact, way before AIDS in the gay community, been a tendency to pair off, to try and be faithful, to have more safe sex and less outside sex. The gay male community has been well known for having a much different norm of sexual behavior than the heterosexual community, both intentionally and also as it evolved through certain periods of history in this culture right now. Because particularly as the whole society ages, as the baby boom ages, it's less attractive to be single. It is less attractive to be out in the market. This is true for the heterosexual role, as well. There, the older society gets, the more likely it is to be faithful; the more likely it is to be somewhat monogamous; the more likely it is to be conservative in attitudes.

So, I think there is some reaffirmation of faithfulness of family, writ large of coupleness, of marriage, writ large for all kinds of couples; but that there will always be these other behaviors that are also true about human passion and human appetites. I think we need a policy that can both say: Here is what we think would be best for you in terms of your emotional life and physical health. But, given that not everyone will act

this way, the nature of people being thus, we also need policy that takes that into account, rather than says: No, and we hope you are deeply punished for your behavior.

MR. KESSLER: Commissioner Goldman.

MR. GOLDMAN: Thank you.

I am talking about problems with colleges and universities, they can be interesting places. I can remember lecturing at one recently; and, before doing so, trying to find out what the local problem was. One of the local problems that they were having at this college was the health department, the health people and the health education people at the college wanted to get rid of the cigarette machines on campus and have condom machines installed. The board of the university thought that cigarette machines on campus were fine, but not condom machines. It shows an interest in the concern of the health of their students.

But that does lead to a question that I have, and that is another point that you made, Dr. Fennell, that you need to develop programs with and by the targets of that education. I have suggested that we ought to look at it also in terms of the advocacy that we do; and, that, from a certain perspective, if we talk about behavior change, we need to focus on the 99 state legislative houses, the 50 governors, the members of the

Congress and the administration, and deal with behavior change on their part, as well. In doing so, one has to, it seems to me, understand and accept their values and talk in their language, presenting one of the things that we've talked about: if you try to talk to people in language that they are not familiar with and bring to them values that they are not willing to accept, then, you are not likely to effectuate change in their behaviors or attitudes.

My question to you is: How can you translate some of the kinds of things that you have advocated, and some of you have suggested here, in that context of translating into language that people who, perhaps, don't share those perspectives or have what maybe some people might describe as more traditional views, without being threatening to their values and without attacking their values head on, and yet, nonetheless accomplish the kinds of changes that they you are referring to?

DR. FENNELL: I think that's a good question. My colleagues might want to add also.

I think one of the things that I try to do is: when I go to campuses and speak, particularly when I'm speaking to administrators, is to go in with the facts, I mean, from work that has been done, because,

quite often, those in the halls of academia will listen to the research studies. So, if I can show them those research studies and say this is what is happening with college students, specifically if I can get information from their own health center saying this is what is happening with your students, we need to do something about this; and you certainly care about the health of your students. And that seems to be a buy-in. So, going in with the facts -- your point about saying that they will have different values, and quite often they do. That's one reason why I tend to use that route.

The other one is -- and you can probably speak to this better. I heard a speaker recently say that, because some national body, such as your American College Health Association, and other organizations, are coming out saying, with guidelines, of what colleges should be doing in terms of HIV education, that it may be down the road that, if a student does get HIV infected and can say it happened while they were a student, and then can go to these guidelines and say, well, the university didn't provide this education, and they didn't make condoms, or whatever, accessible, then, perhaps, they will have a strong case to sue the university and say they are liable because they didn't provide appropriate education.

DR. SCHWARTZ: There is a certain --

MR. KESSLER: Dr. Schwartz --

DR. SCHWARTZ: I thought he wanted --

MR. KESSLER: What I want to do, if you can respond and keep it to about a minute, so that we can continue the dialogue, it would be helpful.

DR. SCHWARTZ: Just that there are limits to facts and what people will accept. I mean, I think education shows that it is related to less sexual behavior, delayed sexual behavior, and more cautious sexual behavior. But, you can put that out. People who are opposed to sex education will say: "No, I don't believe it. I don't think I've got it."

So, what we have to do, in my opinion, is go after a constituency who might be influenced, who will look at the statistics, and build a constituency and bring it to the governors and legislators so that they will believe they have people that they are presenting, that the proportion -- you will never get consensus on these items. It simply does not, will not, exist. But you could get majorities. And that's what you have to bring to people who thing that those -- that that will guide their acts.

DR. LOUREA: I think a presentation of the problems that are going on and the involvement of the target groups is extremely important. If you are working

-- if, as opposed to setting up a dichotomy between "we" and "them," we can talk about the fact that we are all in a problem together, and ask them how they would solve those issues, presenting the facts, it seems to me that education is the only defense that we do have. Being punitive, isolating and disenfranchising people, only creates a situation where we are likely to lie and likely to be dishonest. So, I would involve, as Dr. Fennell does, target groups.

One of the things we do here in terms of designing sex education programs, AIDS education programs, for transsexuals and transvestites, prostitutes, people within the SM community, people within the gay and lesbian community, is to make -- and bisexual community -- is to make them part of the solution, to involve them in the educational process to figure out how they would design a program that is appropriate for their community.

MR. KESSLER: David Barr.

MR. BARR: The word, "faithful," struck a cord to me. And I don't know how appropriate this is, but I'll give it a shot.

I'm a gay man. I'm 35. I've been involved in a relationship. I've lived with my lover, Paul, for 15 years. I love Paul very much. He is certainly a very integral part of every aspect of my life, and he is very

much a part of my family. And, if my mom was sitting here, she would say that, you know, louder than me -- and so would his mom.

The faithfulness that runs between Paul and I in dealing with our life crises, you know, our careers, our emotional, you know, just trying to get through the day; him being there for the death of my father, me being there for the death of his grandmother; Thanksgiving, the shared holidays, you know. My family and his family get together for -- it's as much a family as any other family in America. And maybe because of the obstacles that are presented to us, it may be even just more so, you know, because we got to go over a lot of barriers to create a family and to be accepted. So, the faithfulness that is there between us is incredibly strong.

But, to tie that to what our sexual life is, is not necessarily helpful for us. When Paul -- and it's not an easy issue, you know. Fifteen -- we've been battling over the issue of monogamy for 15 years, and it just, you know, it's not easy. I think that we have found that, when we got pressure on us to feel that our sexual life has to just be between the two of us, it puts a pressure on us that we -- that makes it very difficult for us to be faithful, you know, for us -- all the things that we share together, if that pressure upon us to live that

way sexually is enforced, and we enforce it on each other, it creates a lot of anger, a lot of resentment. It doesn't allow us to express ourselves sexually the way, you know, the way that I need to, the way that makes me happy. So, when that happens, it draws us apart. It doesn't keep us faithful. We practice safe sex. I'm positive; he's negative. And that has a whole set of issues unto itself. That's another hearing.

So, you know, "faithful" is a big word. It means a lot of different things to a lot of different people. But the values that are inherent behind the word are very much a part of our lives, no matter how we practice our sexual life.

DR. LOUREA: So that, for many communities, faithfulness is not a subject of sexual exclusivity. The two are not necessarily synonymous. It is important to understand that.

MR. KESSLER: Mr. Allen.

REV. ALLEN: I've listened, as we've wandered various directions here. One of the things that I would like for you all to address is the issue of authenticity of life, and of the human being -- and the honestly there. We've moved into more of the behavioral aspects and sexuality of who the person really is, and how does one live that out in that context, and what type of

environment it takes to be authenticate. And that's what Harlon was basically talking about: the structural system, that we seem to move from structural systems to, okay, then, let's move to the authenticity of who that person is. That actual real being there.

That's one thing that I struggle with, is -- and if there is help that you all can give, I'd appreciate it -- is: How do we create in that environment the ability for a human being to be real, authenticate, and be nurtured within that personal structure? Diane was talking about the individuals. Well, what is the structure that is needed there? Can there be something that we can do?

Public policy is pretty disconnected to reality at times. I'm just struggling with that. Here we are, as human beings, trying to be real in a very unreal world and a very dangerous world. So, where is it that we start that path? Where is it that it starts and it continues on?

I get very frustrated with the legal system. I am from Texas and I deal with the state legislator there at times, and the insensitivity and the cruelty that takes place in any structure. I was going to ask you about how Ohio deals with your efforts, and so forth, on a state level, but that's another -- a sense of touch, and

the sense of really -- the touch of that essence of a human being and who that person is, we seem to leave out of discussions over and over about this. It feels good to be touched. It feels good to be known and to know another. And, if that's what we are talking about here, that yearning, and we always sterilize it and desensitize it. I just want to get us back to putting that back in the context of how do we deal with the HIV epidemic?

DR. SCHWARTZ: Well, I think gay people have done the society a great service, by demanding to be seen as people, by having issues that challenge mainline assumptions about almost everything. They have made us deal with sex in a way that we really never did before. Even assumptions, such as David Barr just mentioned about what is fidelity? I think government has never really wanted to hear this stuff. It is inconvenient for policy and goes against making large scale policy that is conservative.

But, you know, coming back to an earlier place, that I believe it was Mr. Goldman mentioned, how do we deal with the variety of values out there?

Probably the only hope for any kind of consensus, negotiation and conciliation is at the human level. One of the things that has come out of this horrific AIDS crisis is people telling of enormous human

suffering and loss and grief. Probably many of us, as deeply as we hold our emotional and values, when we see another human being in grave crisis treated cruelly and unjustly, we modify our values. I do believe that the United States is going through such a process. We hear stories we have never heard before. We see people suffer.

For me, the AIDS plague has had very personal meaning, besides my work. My partner, who I worked for 19 years with and did my research that was government-sponsored, NIMH-sponsored, on sexuality, died March 15, from AIDS, suffered horribly for a long time. His partner, with whom he had the most beautiful model family relationship that I would put up to anybody, is also now suffering.

It is a disease without mercy, and it brings you person to person about the preciousness of life and the preciousness of each individual regardless of their differences from you. I think it is a great tool. There is no silver lining here, but there are some utilities. I think it is a great tool to create some policy that extols compassion between people. It helps us understand this, as individuals, and lets people live their lives without punishing them for it in punitive, and -- using the work largely -- in unchristian ways.

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DR. LOUREA: The gay community and bisexual community have had an incredible response to the AIDS epidemic. If we take, if we examine it, take a look at the ways in which we heard dealt with sex education, we've dealt with each other with compassion, I think that you are going to take -- people are going to be amazed at the enormous amount of human compassion, the enormous amount of touching that goes on. I'm aware because I work with people with AIDS, because I am dealing with it in my own life.

One of the things I do with people with AIDS is help them set up support systems of people who can be there to take out the trash, people who can be there and help them on an emotional level, on a physical level. I frequently come in contact with the mothers and the relatives, who come to visit their gay or bisexual sons or daughters, and are overwhelmed by the human response that the community, that their community has given them.

One of the things that you need to know is that, if you are a sexual minority in this culture, frequently you have had to leave your family, your loved ones, the people that you grew up with, not only because they might be punitive, even if they are not in support of -- they cannot give you the kind of support that you need different from the people who are living the lifestyle

that you are going through. So, many of us have left our families, moved many, many miles away, and reestablished our families.

What the heterosexual families come into contact with is amazement, that their friends are there taking out their trash, their friends are there changing their diapers, their friends have been -- as one mother pointed out, done more for my son than any member of my family would do for me, if I were in similar situations. So that I think that the role models are already there.

The other thing that is important to remember is, that, we must be able -- if we want people to deal with their sexuality, we must provide a context where we can talk explicitly about sexuality. If that is not the language or vocabulary that you use, you need to know that other people do use that language. And, if I am going to be able to talk about how am I going to address the fact that my basic sexual behavior has been rimming someone, if I find your burns up if I say that, I know that I cannot talk to you about that. If my doctor does not feel comfortable with my sexual behavior, probably what I will do is I will not tell him my sexual behavior. If an instructor is up there giving me a moralistic value about what it is I should be doing, and it is different than my understanding of my behavior, I will shut down and

I will turn off and not hear any of the valuable information that you have to give.

So, part of it is recognizing the diversity of human sexual behavior that is out there, and getting -- I feel that the best that we can do is help people to make decisions from information, as opposed to ignorance.

MR. KESSLER: Because the sessions are designed to somewhat overlap, I am going to ask Sue Hyde to hold her comments until the next session. I think you can probably weave that into your presentation.

Commissioner Diaz had a comment or a question; and, then, we will have to take a break.

MS. DIAZ: I would like to come back to the issue of faithfulness. When the first Surgeon General's Report on AIDS was issued, a number of us that were doing discussions with them, groups from minority communities, to better understand or pretest that document, found just what you said, Dr. Lourea, that faithfulness does not equate with physical exclusivity.

MR. KESSLER: Eunice, can you speak louder.

MS. DIAZ: We ask that you revise and explain exactly what that report is going to do with faithfulness. Particularly, in the Latin community, a large number of men, who consider themselves in faithful relationships, but that did not equate with physical

exclusivity. Today, the panel has not focused on the ability to reach individuals who are in positions of being able to train others in our community about the kinds of information you have given us. Other than Dr. Fennell, being in an academic center, he did not talk about how his work impacts other professionals within the college setting, other than through the American College and CDC works.

I really would like to hear from you where you feel that efforts should be best directed societally to get the kinds of facts and information about sexuality, sexual differences, and the options for the populations so they can begin to influence public policy in some way that it is meaningful. Your knowing, us knowing it, perhaps does not have the impact of the natural communicators in our community, whether they be other college professors, ministers and clergy, other physicians and people of the front line of interacting with our community. Information would be very, very helpful and beginning to mold public attitude that, in turn, begins to translate into public policy.

I just wondered if anyone of you can just highlight that for me.

DR. SCHWARTZ: One quick response, and I bet everybody does.

One thing the federal government could do is put money into research on sexuality and into sex education in various professional contexts. Let me be very specific about two examples.

There is a declining amount of sex education about sexuality concerns because of AIDS. I'm not even talking about unrelated disciplines. I'm the only person who does sex education often for our resident in psychiatry or of insurance. If you go to a medical school, one of the biggest medical school complexes in the United States, highest federal funding, please, this is so inadequate it is embarrassing to talk about.

Second place: How about at the centers for dissemination of information? Let me take one like the Centers for Disease Control. They are not getting the kind of information about sexuality that often goes out in highly related outcomes.

Let me give you a very specific example that I've been involved in, and that is reviewing the screens that went out between 1981 or 2, and 1985, to blood banks, which were the screens to ask people whether or not they should give blood, whether or not they were in a high-risk groups. I've been taking a look at them because they are so inadequate that they are now the basis of suits across the country for inappropriate safeguards for people, for

the blood banks, and for people giving blood from the blood banks. One of the things that has been shocking to me were these screens, were they gone over by anybody who has a social science background? No. Were they ever gone over with somebody who had sex education experience, such as what the language means to different people reading these things? No.

So, there is such a complete problem that you would really need -- I think it would be a terrific thing to concentrate on all of the various levels of which this could be an enormous governmental contribution.

DR. LOUREA: I think it is important -- we have an arrogance about us, as educators. We feel that we have the answers and you have the problems. The most effective AIDS education programs that have been done in this country have ones that have relied on community-based programs.

While I have been frequently at odds with the Public Health Department in San Francisco, one of the genius things I felt that they did do here was a program that was targeted for adolescents in the predominantly black neighborhood of Hunter's Point. What they did was they did -- they had a contest, a rap down about AIDS. There were prizes that were offered for the students who come up with the best rap about that. What they did is

they used the language of that community and the students had to go find out information and show the connection between drugs, sex and AIDS, and put it in a performance that was exciting.

One of the things we did with the Gay Latino Community, the transvestite Latino Community in San Francisco, was let them put on a performance, a drag show performance, talking about AIDS.

It is important -- one of the things that we must see is that all of us are in this together, and that we all have contributions to make.

MR. KESSLER: Dr. Fennell, you have the final word.

DR. FENNELL: Thank you.

Just to quickly comment on some efforts that are going on to try to train college professionals. There are a couple of CDC agreements with the American School Health Association and the American College Health Association in which both of those organizations do either one- or two-day in-service workshops that are either regional or statewide workshops for HIV AIDS education. It tries to bring in the school nurse or faculty members on college campuses. However, I must admit it is for those who choose to go to them. So, there is still a lot of people who aren't getting the information, and that

tends to be a problem. Because, my students have said to me: Well, I sit in your class and I learn this; but, then, when I go to my other professors' class, they will say something that I know is incorrect, not because you said it, but because of the work that I've read, that you give us in the class. There is a need to try to reach more people.

Also, in the state of Ohio, for the last four years, we do, myself and another colleague do, a statewide training workshop for college faculty and staff. Here again, it is for those people who choose to come. So, there are a lot of people who are still missing the information.

MR. KESSLER: Well, thank you all for a very stimulating start to this day.

We will continue in exactly 15 minutes. At 10:35, we will go on with the next session.

Thank you.

Off the record.

(Whereupon, a 15-minute recess was taken.)

MR. KESSLER: On the record.

Will the panelists please join us, and will the commissioners please take their seats.

(Pause.)

Our panelists are before us, and the order

of presentations will be Eric Rofes, followed by Richard La Fortune. I can't pronounce your Native American name. Dr. Marjorie Hill will be next, Autumn Courtney, followed by Paul Davis and Ms. Sue Hyde.

Why don't we start with you, Eric.

Welcome.

The Experience of "Sexually-Identified" Communities

Autumn Courtney Paul Davis

Marjorie Hill, Ph. D.Sue Hyde

Richard La Fortune Eric E. Rofes

MR. ROFES: The last time I testified in front of the Commission in Washington, D. C., I was in a suit and tie. I'm not wearing this leather to shock you, but to make, reality, the ultimate point of my testimony before you: that there is not just one gay community; but many gay communities, each with our own customs, our own traditions, and our own history. And I think you will get a sense of that from this panel.

The leather I wear may seem unusual, especially to those of you that don't live in San Francisco. But this is the clothing of a specific community and a specific culture of which I am proud to identify, the gay male leather community. I certainly encourage your questions, but let me explain a bit, first.

I grew up in New York City, in Long Island,

the son of Jewish parents, who were the children of Russian immigrants. And growing up, our family struggles with two very different American realities, which I think many of you are familiar with. The concept of the melting pot that said you should assimilate and fit in, and mix into American culture and all end up looking alike; and the experience of Jew hating and xenophobia in America, which led the Jewish community to learn to take care of our own and protect our own. I was brought up with an inherently American concept of community that said I should live in a world with others of different cultures. I should preserve my Jewish identity, my religion, and my traditions. Because of anti-Semitism, I had to remain rooted to the Jewish community. When push came to shove, only my people would be there for me.

So, with this mixed message --

MR. KESSLER: Let me hold you so that we -- I don't want your message to go out --

DR. OSBORN: Excuse me for interrupting you Eric, but we are so happy to see Belinda. Some of us haven't seen her for quite sometime, and we are just thrilled that she is able to join us. So, pardon the interruption.

Welcome, Belinda, we've missed you a lot. We are delighted that you are here.

MS. MASON: I'm sorry I'm late.

(Applause.)

MR. KESSLER: You may continue.

MR. ROFES: The messages I got about what community was like in America came from different sources. They came from my family, they came from a synagogue, they came from the newspapers I read. They gave this mixed message of assimilation and separatism. That gave messages that said you should fit in, and they gave a message that said you should stay apart.

So, it was around the time of my Bar Mitzvah -- hello, Belinda -- that I realized I had attractions for other guys. I realized I was homosexual, and I knew what that meant in America. And this concept of community, American style, came home for me. Because, I thought I had -- my initial sense was that I had to live a life of total denial. This was in the late 1960s. I thought it meant I could never tell anyone about this. I could never love myself or like myself. I thought I could never kiss another man. I thought I could never be public or open with the people closest to me about it. This was the message I got from family, from my synagogue, from the newspapers I read.

It was interesting that, at the same time I was getting mixed messages about being Jewish, I started

learning that these mixed messages applied beyond Judaism, and applied to many communities. I was all of a sudden in another community that I didn't know there was a community about. But, soon I learned and heard people talking about the gay community. I had no idea what they meant, as a young homo in America. I couldn't understand how people would form a community around sexual desire. It didn't make sense to my understanding of community, which was rooted in traditional Judaism. The concept of community formed around a sex act or sexual desire just didn't fit.

Although, as I learned more and more about what the gay community was, as I went to college and started exploring it, I realized that gay communities are a lot more than about one's sexual identity -- although they certainly include one's sexual identity. That they are as much out of love for a culture and history and traditions as out of the need to take care of our own. And that reminded me of my Jewish community background. Instead of anti-Semitism, we were dealing with homophobia, or hatred of queers. The gay community, for me, was as much about loving men as making the world safe for men who love men. I learned that a gay and lesbian community and a gay, lesbian and bisexual community existed that included other people, as well.

What I want to impress upon you is what the

gay communities I have been a part of have offered me, have been very important to making my life wonderful, and to protecting me and keeping me healthy. They have been a safe place for a part of my identity that is not safe anyplace else. It isn't safe in the Jewish community, isn't safe in the American concept of the melting pot. The gay communities I have been a part of have offered me political values. Some political values that I shared as a Jew, some new to me. They have given me an exploration and a daring around sexuality. Not the sexual orientation of my partners, but the sexuality I had, what my sexual desires were, that I don't think I would have had otherwise.

So, I sit before you as a gay man who is a part of the gay male leather community. A community that isn't talked about much in federal hearings, doesn't receive government funding to prevent HIV infection; and, frankly, isn't real popular in the larger gay community even in this city. Yet, we are a community that has much to teach about sexual identity, much to teach about the experience of persecution, and who has learned a whole lot about community building on the fringe of an already identified sexual minority. I could be a transvestite or a drag queen sitting here and saying very similar things. I could be a youth hustler. I could be a radical fairy.

These are all sexually identified communities within what people usually call the singular gay community.

Ultimately, the point I think people from all these communities bring is the same. It is the concept that, as much as we are a part of a broader group called the gay community, we are different.

I certainly am open to questions you have about sadomasochism, bondage, fetishism. I believe that wearing leather pushes people's buttons in a deep and personal way because it raised issues of explicit sexuality, of power, of control, of roles, and I am happy to talk about it, if you would like to. But, what I want to make sure you know is that, we are not one sexually identified community; but many communities, all are impacted by HIV, all are rising to the challenge of the second decade of HIV, and all, in my opinion, have had impressive integrity and vision over the first decade.

MR. KESSLER: Thank you, Eric.

Richard.

(The next speaker, Mr. LaFortune, initially spoke in a Native American language and was not translated into English.)

MR. LA FORTUNE: My name is Anuk Suk (phonetic) in the our language. That means little man or little woman. I come from the band of (Native American

word) nation. (Native American) means people who dwell by the great river.

Madam Chair, members of the Commission, I realize that we are talking about emerging and development of sexually-identified communities. In the context of American society, it is -- I'm trying to figure out how to approach it. Because, as you may or may not know, we've been here for about 50,000 years in these ancient motherlands, and the majority of our non-North American neighbors have been here for about 12 generations. We've been here for about 12,000 generations, and we do have traditions that all very closely interrelated: spiritual, social, sexual, however you want to look at them.

Specifically, what we're looking at today, as I said, in the American social context, it's a little bit difficult to talk about. Because, what we are talking about is the emergence of a sexually-identified community. We never used to have gay and lesbian. In the Upik (phonetic) language, we don't have two genders. We have four genders. We have unlun (phonetic), it means man. Uhanuk (phonetic) means woman. Uhanohuk (phonetic) means similar to a woman. Unmuk (phonetic) means similar to a man. (Native American phrase, not translated) means different kind of people. And for us, the different people, we had ever since we can remember been assigned

special spiritual roles. I guess what you could say in the context of postmodern society, we are trying to figure out how to make these roles fit into the context of our lives in contemporary American society.

One of the things that I point out, when I speak frequently, is: When we look at the Judeo-Christian roots of federal, state and local city governments, the laws, we recognize -- I mean, I recognize it's frequently lost in the dust. The laws that we experience and are expected to abide by, from day to day and hour to hour, derive from social and religious mores and assumptions, which the European and Caucasian American cultures inherited from Semitic and the Arabic people, 6 or 8 thousand years ago, and about 12 or 15,000 miles on the other side of the earth. I realize that these laws are not appropriate for my people.

The word "sodomy," as you all know, comes from the name of big, old settlement, old community in the desert, Sodom. And, as I said, it's a long time ago and a long ways from here. It has never been a part of our cultures.

In the native communities in this continent, there are a lot risk considerations that we have to contend with that a lot of other people, including minority communities, don't have to think about. There

are many multiple risk, including sexual behavior of young persons; high rates of teen pregnancy; chemical use, including very high rates of IV drug use. All these things place us at great risk.

I'm just trying to put this in a little bit of context for you. It's really hard to do in five minutes.

What I do want to say to you, though, is, in general, what has been noted by at least one western scholar, who studied our cultures, sexuality hasn't ever been seen as something evil, or taboo, or a disagreeable task that really does have to be done in order to continue the species. It has most often been understood and you can see this in our what would be possibly seen in the Christian community as high church. In our most sacred ceremonies, sex is always made fun of not in a denigrating way, but in a very happy, healthy way. Because, when you stop and think about all the things that we as human beings go through, our own sexuality, it is kind of humorous. And this is the way we've always understood it.

We do have, in all of our languages, of the 350 remaining nations existing in North America, we have our own words that describe the roles of what are known as gay and lesbian people, bisexual people. In the traditional way, though, and these traditional ways are

still being exercised, we have a lot of responsibilities which have always ranged from diplomatic and ambassadorial to artistic, to social and ceremonial roles. We strive to preserve these and rehearse them in the context of our communities. It has always been considered a privilege to have a gay or lesbian person as a member of your family, or to be able to marry one. This gives you a little bit of an idea of some of the things that have guided our ways at looking at humanity.

The idea of polarities, in terms of sexuality and gender, doesn't make a lot of sense in the context of our cosmos and our social constructs. Sexuality and especially a person's high roles, somewhere between the gender, the masculine and the feminine, those people who occupy gender roles between the masculine and feminine are seem as being gifted. And, sexuality, in general, is seen as a gift from (Native American term), the creator, or the creators of the universe.

We have been, and we continue to be in modern day United States, we continue to be called savages. Every time a cowboy and Indian movie is aired over the airways, here and in other parts of the world where they happen to be very popular, we are savages and less than human all over again. It perpetuates very wrong ideas about our humanness. Yet, we savages, for millennia

upon millennia, have understood and affirmed the role of women, of our children, our elders, and of our gay and lesbian people. Where the differences collide, there is a lot of confusion and we do have to deal with that as part of our oppression.

1992, we are at the 11th hour of a 500th anniversary of a holocaust, and it hasn't stopped. However, we have not stopped being here. We have always been here, according to our tradition. And, as long as there is life on earth, we will be here. And this understanding of sexuality is part of our sacred tradition.

Thank you.

MR. KESSLER: Thank you.

Dr. Hill.

DR. HILL: Good morning. My name is Marjorie Hill. I'm director of the Mayor's Office for Lesbian and Gay Community in New York City.

From that vantage point, I'd like to share with the Commission some of the observations I have made, as it is my responsibility to know very well what the concerns are of lesbians and gay men; how they access city services, AIDS services being inclusive in that, and some of the dilemmas that confront those communities in New York City and across the country.

The Mayor said, a couple of months ago, "I'd rather be booed in a parade than bow down to the forces of exclusion, fear and intolerance," shortly after marching in the St. Patrick's Day Parade, where he marched with the Irish Lesbian and Gay Organization. This was clearly a victory that received both national and international attention. You may ask why, other than that's my boss, would I mention it today.

(Laughter.)

I think that it points out in a very clear way what three of the issues that face the community at large, and lesbian and gay and bisexual individuals across our country. And those three issues are invisibility, intolerance and inequality.

Too frequently, sexually-identified communities are ignored or dismissed as not that same as other minority disenfranchised groups. To be denied civil liberties based on bias and prejudice, regardless of whether it's because of your gender, religious affiliation, ethnicity or sexual orientation, is to be denied. There are two key differences, however.

One, is that which has to do with how one is publicly identified. It is rather obvious that I'm African-American. Equally, it is obvious that I'm female. It is not obvious that, however, that I'm a lesbian. In

fact, after being sort of identified as a public lesbian, being on numerous talk shows and being involved in gay and lesbian organizing for over 12 years, periodically someone asks me -- I'm a psychologist by profession -- did I get this job because working with lesbians and gay men with my clinical specialty? Or being asked how does it feel to promote lesbian and gay rights? How does it feel to look out for their rights? And the whole issue of being visible, and the whole issue of even as, again, a publicly acknowledged lesbian, that individuals can so easily deny that, I think speaks to the issues and concerns of our community.

The media, public institutions of learning, whether they be a grade school, high school -- and we've already heard about how poorly colleges are doing around sexuality -- legislators continue to ignore the lesbian and gay community. Even in situations where there is some recognition, it is often white, gay male, or questionable in terms of true inclusion.

Recently, I participated, conducted a personnel training for Department of Personnel's EEO officers, and dealt with the issue of inclusion, sexual harassment, how lesbians and gay men might be encouraged to report if they felt there were issues of violations. And, after doing what I thought was a thorough job, I had

an individual ask me, who commented that it was a thorough presentation, and why do you have to tell anyone? Which speaks to the question of tolerance. That although we in our society, those of us who think of ourselves as progressive and inclusive, can say it's okay to have a panel, it's okay to speak of these issues, that to have true inclusion is not blatantly heterosexist in its orientation too often occurs.

The example that I sometimes give is: If we, for one moment, thought of a world where everyone looked female, but there were 10 percent of those individuals of that, or our society, of this society, who looked female who were actually male, but had to make a decision about whether they would tell anyone or not, what that would mean if this in this all presumably looking-female society, that the church said that being male was wrong, that it was sinful, that it was a psychiatric disorder. If in this society that the individuals who decided to come out as male were subject to criminal penalties, were subject to having their children taken away from them, and were subject to also being bashed, then, you get a picture of what's it's like for gay and lesbian organizing, and the whole concern around the safety and prevailing heterosexism.

The state of -- the final thing I would like

to say in terms of inequality, is that the state of gay and lesbian liberties across our nation poignantly reveal significant inequality. Only a handful of municipalities have domestic partnership legislation. Even few of those municipalities have civil rights legislation that protects lesbian and gay people. Sodomy, in many states, still includes sex acts between same sex individuals. Lesbian and gay relationships, and the definition of family continues to be an issue of controversy. The Sharon Kowalski Case being an example, where a -- for those of you who may not know -- a lesbian couple is being denied, that the woman who is now incapacitated is being denied the care and affection of her life partner regardless of what she says, regardless of what medical experts say. And again, this is the question of family and, perhaps, faithfulness that David talked about earlier. In spite of this, the gay and lesbian community is gaining in its visibility, in its unity.

I have attended, in the past six months, three national conventions, one being the National Black Gay and Lesbian Leadership Forum; the second being the National Lesbian Conference, which is historical in Atlanta, just about three weeks ago; and the National Gay and Lesbian Task Force Conference in Minneapolis. The issues around dealing with our rights, the issues around

gaining custody and maintaining custody of our children, and having our families and our relationships respected; the issues around bias violence and how, in the United States, it is projected that, last year, bias violence against lesbian and gay men rose 200 percent. In New York City, bias violence, according to the New York City Police Department, against lesbians and gay men rose 109 percent. If all of us who know anything about crime statistics will easily recognize that all crimes are underreported. So the issue of safety and visibility are issued that impact AIDS services, other social services, education and, again, visibility. But, in spite of this, the amount of organizing that's going on, both nationally and, as a matter of fact, internationally and locally, is really quite amazing.

One of my responsibilities is to meet with lesbian and gay organizations and here what their concerns are. And I have the opportunity to meet with S&M groups, the opportunity to meet with parenting groups, the opportunity to meet with lesbian and gay people of color organizations and, interestingly enough, lesbian and gay clergy, interestingly enough the concerns are pretty universal: lesbian and gay men are organizing for increased visibility to have the right, the right to be and exist in a society that respects individuals for who

they are, not based on whom they choose to love.

The struggle will continue and there are a lot of nuances within the community that are relative to AIDS, but exclusive to the issue of AIDS.

I will be more than happy to address any of your questions, but I thank the Commission for pulling together and organizing this panel to provide individuals with some grassroots experience an opportunity to share with you our concerns.

Thank you.

MR. KESSLER: Thank you, Dr. Hill.

Autumn Courtney.

MS. COURTNEY: Hi! My name is Autumn Courtney. I am a bisexual woman.

What I do in my day-to-day life is organize within the bisexual community. I work with individuals and groups across the United States in a coming together and a coming out around the bisexual identity. It's an identity that has been very difficult for us to come to grips with because of the homophobia and heterosexism that exists in this county. Our concerns are of homophobia and, as my fellow panelists have said, we share the same concerns as lesbian and gay people; but we also have our own community, and we struggle with our own identity. And that's what I would like to address.

Early in the epidemic, we were very involved here in San Francisco with education around the AIDS epidemic. We were some of the first people -- because we are so used to talking about our sexual identity and what we do sexually, because people seem so fixed on that specific aspect of us, we were able to talk in very explicit terms about the AIDS epidemic and what we could do to make our sexuality more safe to stop the spread of AIDS among us. We were hit very hard in the early days.

Because it was seen as a gay plague, a lot of people, who were coming to terms with their own bisexuality, did not want to come to grips with their gay side. From that, the lesbian and gay population has grown a community that is more powerful.

Also, bisexual people have been discriminated against or have been left out. As the term gay and lesbian is used over and over again, the word bisexual is not addressed. Now, the word is being tagged on, but we want it to be more than a tag. We want it to be a real -- have a real meaning behind it, that we're talking about real people who have same sex and opposite sex relationships on a pretty much day-to-day basis, or month-to-month basis, or year-to-year basis. The bisexual people are very diverse in their sexuality and of who they are.

Frequently, in reaching, in becoming involved in the health care community, I would just like to give an example of bringing it kind of closer to home.

In 1986, I was living with a man. I had a male lover at the time. Up until then, I did not think that the AIDS epidemic had much to do with me. Up until that time, there was very little that was being put out about women and AIDS. That hasn't changed all that much, except for in major cities. Most people think that it is still a gay men's disease. We know this is just not true.

In 1986, my male partner was diagnosed with AIDS. It wasn't really until that time that I realized that I might be at risk, or that I might be infected. When I went to go get tested, I was very lucky to find a compassionate women's center to do the testing for me and to give me some advice, but they had no support group. When I went to a gay male support group, where people who were waiting to get their test results back, I wasn't accepted. They couldn't deal with the fact that a woman might have the same issues that a gay male might have in dealing with the AIDS crisis. Fortunately for me, I tested negative and have continued testing negative, even though I'm intimate with my bisexual male partner.

My experience was just horrifying, the way that I was treated and discriminated against, in terms of

not having access to community group support groups. Slowly, that has changed. But, even now, at the San Francisco AIDS Foundation, there is only one bisexual counselor, and he is overloaded, dealing with heterosexual and bisexual men who are married. The needs and education of bisexual women has failed to be addressed.

In looking over the literature at the AIDS Foundation, you will see the word bisexual at the top of gay men, gay and bisexual men dealing with AIDS. But, later, the word "bisexual" is dropped throughout. There is also no pamphlets directed towards bisexual women. There is just these kind of vague terms of "same sex," and "opposite sex" behaviors.

What we ask of the Commission, the lesbian and gay community, and the general public at large, is validation of our sexual identity, that we are bisexuals, that we are not confused, we are not fence sitters; that we are generally attracted, both sexually, emotionally, erotically, sensually, intellectually, psychically, to both genders. That that may not be a 50-50 split. That we may fluctuate, that our sexuality may ebb and flow as we change. What we ask is acknowledgement of this identity; that the word, "bisexual," be included with the terms "lesbian and gay" when appropriate' to be included with the terms "heterosexuality and homosexuality" when

appropriate, because we are unique and different in our sexuality; that we are not automatically stigmatized as being nonmonogamous. That is the testimony here earlier that some people are serially monogamous, whether it be, you know, relationships of a couple of days, or several years.

We would like to be included in the education material. There is a lot of people who don't identify with the gay community and are not receiving this education that could be given to them. And, as we know, education really works in stopping the AIDS epidemic. We ask that the terms "bisexual and bisexually active" be included in AIDS education materials. And with that, targeted groups of bisexuals would be placed on your list of people to be educated. There are whole pockets, especially people who are not around the urban areas, that are bisexually active and are not getting education materials.

The last thing is our involvement. People who do self-identify as bisexual should be included in the development of education materials.

Thank you.

MR. KESSLER: Thank you, Autumn.

Paul Davis.

MR. DAVIS: My name is Paul Davis. I

represent the AIDS Program in Los Angeles.

In preparing for this, in terms of the sexually-identified community and in terms of the --

MR. KESSLER: I'm not sure your mic is working. Can you -- No, it's not. If you could --

MR. DAVIS: Okay?

DR. OSBORN: That's it.

MR. DAVIS: My name is Paul Davis, Director of Education from the Minority AIDS Program in Los Angeles.

When asked to serve on this panel, I looked at the topic of sexual-identified community and began to realize, since I would be talking in terms of black gay males, that the topic really didn't refer to us in the sense that we are somewhat, to a large degree, invisible. I looked at how to approach this, and I said I would approach basically from a personal standpoint. One of the things that I do, in terms of doing education, is, we began to get some of our PWAs to take risks in terms of getting on posters, or talking to groups in the Black Community about the whole thing of AIDS. But I decided to use my person and take a few risks myself.

First of all, just to let you know who I am, I am a black gay male, who is a father of two. I'm basically from the Bible Belt of Lynchburg, Virginia,

headquarters of the Rev. Jerry Falwell, with a 23-year old son who is HIV-positive. I'm one who has been very active in the Civil Rights Movement of the early '60s, part of the march on Washington in 1963, and one who struggled for a long time in terms of his own sexuality; one who hid his sexuality during his college years at Hampton, and later working at Hampton Institute in Virginia as the assistant dean of men, and later assistant dean of minority affairs at New York University. Basically, one who was in the closet. One of many blacks who simply moved to the large urban areas, such as New York and later Los Angeles, because one found that one could sort of melt into the crowd and not stand out.

I'm a black gay male who has -- I was sitting down the other night and put together sort of a list -- who has been with over 250 persons sexually in my lifetime, persons I can remember by name and face. Those do not count those I cannot remember; and one who is still HIV-negative. That becomes a dilemma in terms of working, particularly in this field, in the sense that realizing that it is not simply a question of how active one is sexually, but how one presents or what caution one takes.

I grew up not knowing of an openly black gay community, living somewhat in a close society and a secret society: house parties, individual friends that one met.

Let me state from the outset, I do not pretend to represent the black gay community, but maybe only a segment of that community, which is a new and emerging, politically black gay community, that is out of the closet, and basically plans to stay out of the closet. In that community, there is a very diversified community. There are transvestites, there are transsexuals, there are drag queens, there are various titles: sissies, homosexuals, persons in S&M, persons who consider themselves gay, persons who consider themselves bisexual. Black men who have sex with men is a title that we use. Black men who have sex with men, but who do not self-identify. Black men who have sex for survival, such as food and shelter. Or black men who have sex because of their environment, such as in the large proportion of Blacks who are in jails or in the prison system and later coming out and go back into a heterosexual lifestyle. It is a diversified community.

Looking at the community in LA, we sort of speak a lot of times of what is called the community north of Wilshire and south of Wilshire. North of Wilshire is the Hollywood-West Hollywood community that sort of intermingles with the white gay community. The community south of Wilshire that includes Watts, Compton, Ingelwood, and that's a totally different community. The two

communities sort of do not mesh. There is a young gay community and there is an older gay community. There is an affluent gay black community and a very poor, impoverished gay black community. And there are black gay males and black gay females that still also have various issues. One of the things that was alluded to by an early speaker was that a large number of my sisters in the black lesbian community who still feel that they are immune to this virus, but who still practice both male and female.

Looking at the development of this community, as I indicated earlier, in the '60s, basically this community was made up of private parties in one's home; and, oddly enough, in the Black Church. In the '70s, basically black gay bars began to open, or gay bars began to open, so there was still the parties, there were the bars, and there was a church.

I indicate the church because the black gay community has always been in the black gay church. A friend, a person at the National Black Gay and Lesbian Conference, made the comment: his father was a minister, and one of the deacons in the church came to him and said: "You know, this person that plays the organ, do you know he's gay? We need to get rid of him."

And the preacher turned to him and said, "Do you know how to play the organ?"

He said, "No."

His response was: "Leave him alone."

That has been something that has been very, very prevalent within the Black Church in the sense that many Black Churches have been built with the singers and organists who were gay.

In the '80s, again, there were basic parties, bars, churches, and a few social clubs in LA. There were such social clubs started, such as LA Card Club, the Achievers Club, the Cosmopolitans, and Excalibur Social Club that I was a founding member of in the early '80s.

In about 1985 in the black gay community in LA, new things began to happen, such as Unity Fellowship Church that started out in '85 with about 12 members, under the leadership of the Rev. Carl Dean, mainly a primarily a black gay church. Today, that congregation numbers over 500 and includes persons of very diversity, racially and sexually; but primarily a gay organization.

Also, such organizations as the Minority AIDS Project have made a large number of changes in that community in the sense that, prior to '85, there was nothing political within the black gay community. Since then, in 1986, Black Gay Men's Coalition for Human Rights was formed, an organization that was basically formed to

deal in the political area -- where we brought politicians in to talk to members of the community in terms of who we were going to support. The Black Gay Men's Rap started, where we've had over a hundred and some black gay men, who periodically attend that rap. The Black Gay Men's Exchange, the Afro-American Cultural Alliance, the National Gay and Lesbian Leadership Forum. Even in LA now, we have a magazine called "Black."

Again, this being a minority community, it's becoming much more visible now in 1991. One would think that the AIDS virus would have driven further into the closet persons in the black community. A number of them are coming out in the political arena. A number of them are challenging the Black Church. A number of them are redefining the whole question of what a family is.

Yes, there are a number of problems that we deal with in terms of this virus within the community; but, some of the problems that we still have are drugs, we still have gangs, we still have poverty, we still have job discrimination, racism and other forms of discrimination. We are a very diversified community.

Thank you.

MR. KESSLER: Thank you, Paul.

Sue Hyde.

MS. HYDE: If this doesn't reach, I've been

handed a bull horn.

(Laughter.)

MS. HYDE: Thanks Paul. Thanks Larry.

Good morning, Dr. Osborn, Ms. Mason, Ms. Byrnes, Mr. Kessler, members of the Commission, witnesses, guests. I see we are all here. Thanks to all of you for coming out this morning.

I worked for four years at the National Gay and Lesbian Task Force in Washington. And, while there, I was the director of what we called the "Privacy Project," an organizing project to repeal sodomy laws, or repeal the portions of sodomy laws that criminalize private adult consensual sexual behavior.

So, I was very interested in the comments of the first panel and had wanted to point out to the members of the Commission that the resistance to knowing about sexual behavior and sexual attitudes is quite great, and was demonstrated two years ago -- I think it was two years ago -- when the United States Congress refused to fund a study that had been proposed by NIMH to comprehensively investigate sexual behavior and sexual attitudes of people in this country. And I think the Commission would do a great service to all of us to recommend that such a study be funded.

I also want to thank you for taking this day

to talk with us, to listen to us. I hope that Dr. Fennell's education adage will not be operative today. That you will remember what you hear and learn from what you see, and go do whatever it is you do, that the day will, in fact, be useful.

Some of my colleagues have spoken in a very personal way about their experiences of growing up, as gay and lesbian people and bisexual people, and finding their places in the world. Now, coming out can only be, I think, an individual process. It is excruciatingly personal. Because, in coming out, most of us place ourselves outside of something that's very important to us. Now, of course, we place ourselves outside a closet, which is sort of elemental to us, and that's good. But we also very well may be placing ourselves outside our families, outside our circle of friends, outside some parameters of acceptability for our chosen careers or occupations. But we, in fact, don't choose to locate ourselves on the outside. We live in a culture that insists on the dominance of heterosexuality. And it's the culture that consigns us to the outside, to the margin, to unacceptability.

The deepest contradiction of my life is that I had to come out to come in. I had to move outside of my family, outside of my friends, I had to move outside of

acceptability to become whole and to realize my own competence and my own capability. I had to leave home to get home. Now, it's a process that is repeated over and over by lesbian and gay people. And it's a process that is experienced individually and collectively.

No queer is an island. Who said that? Nobody can be gay or lesbian alone. People can be homosexual alone. In fact, many people have done it. Roy Cohn and Liberace, perfect examples. They lived in relative isolation from a gay and lesbian community. In fact, where adamant in saying that they did not belong there, and adamant in rejecting it. So, they weren't gay and lesbian in the sense of joining with and participating in a community.

Now, I've said that we are on the outside, on the margin, so what can I possibly mean by community, a word that connotes centrality and safety?

For the last four or five decades, in fact, for the length of my lifetime, lesbian and gay people have been involved in the project of creating and building culture and community. I was thinking about this, this morning. That, if anything, lesbian and gay people are the renaissance people of this century, at least in so far as, I think, as this country goes. We emerged from secrecy, we emerged from shame, we emerged from

stigmatization to cultivate an incredible flowering of culture. Out in these margins, we teem with activity. There are gay and lesbian choruses and theatres and film. There are gay and lesbian print and electronic means of communicating. We have our journalism. There is gay and lesbian athletic organizations. Yes, we do have the Gay Olympics every four years. There are gay and lesbian recreational clubs, political organizations of almost every kind -- not every kind, thank you very much; but almost every kind. There are gay and lesbian caucuses of almost every major professional organization. There are gay and lesbian churches and organizations for gay and lesbian religious people of every denomination, every religion. The proliferation of gay and lesbian culture is seen and felt really in every part of this country. When we say we're everywhere, we are not kidding around. But we still are somewhere out on the margin. And the evidence of that is all around us.

I grew up in Illinois, a great state. Illinois, in 1962, when I was ten, became the first state to reform its criminal code such that private adult consensual sexuality would no longer be a felony. But, prior to that, every state in the country had one of these phenomenally unenforceable sodomy laws. From '62 to '83, 24 other states reformed their criminal codes similarly to

Illinois. But just in case we thought we were making progress on this particular issue, in June 1986, the Your Honor Supreme Court in a case called Bowers v. Hardwick or Hardwick v. Bowers -- I forget the way it goes; I'm not a lawyer -- but just in case we thought we were getting somewhere, upheld the Georgia Sodomy Law and declared that there is no fundamental right to engage in private homosexual behavior. Oh, right back where we started.

Plenty of gay and lesbian people have served in the United States Military, thousands, in fact. But for 50 years, the Department of Defense has engaged in a policy that has, I think, the force of law, a written policy to exclude and discharge those gay and lesbian soldiers and sailors who become identified to them. It is called Policy Directive 1332.14. The Commission may be interested in investigating that a little further, particularly since Secretary of Defense Cheney sits at least officially on this Commission.

The evidence is everywhere. Not more than five days ago, I'm sitting drinking my coffee, reading the newspaper, I open up the paper and the Massachusetts Catholic Bishops have just wanted everybody to know that they were going to redouble their lobbying efforts to make sure that no governmental agency, no governmental decision-making body in the state would recognize gay and

lesbian families. Oh, so what does that mean? That means that my lover and myself and our children, when we have them, will not be recognized as a family by the state. On a daily basis, we experience our marginality no matter how fully we feel apart of our communities.

The Reagan-Bush indifference to the AIDS epidemic, in some terrible and tragic way, was just business as usual insofar as our lives were concerned. It was in a just awful, terrible way another nail in the coffin. Just more shameful and vile business as usual. And the handwriting that predicted that enactment of federal policy concerning the AIDS epidemic had been on the wall for centuries.

There is one really important feature of coming out -- well, there are many important features. But, as far as our communities goes, as far as our political development goes, there is a very important feature in coming out. It makes each of us deeply, deeply invested in social change. The risks of coming out really mold us, us gay people, into activists. Because, we know that only by changing society's enforcement of the policy of heterosexuality for all will we ever achieve any measure of safety. Our survival depends on our willingness to press for legal, cultural and political change.

So, in 1991, the gay and lesbian political movement is among the most vigorous in the country. We're in cities, towns and villages, in rural areas all over the country, organizing, working, cajoling, pleading, lobbying, pressing for an end to discrimination and violence and full citizenship, with full rights and full responsibilities. In 1987, we marched, 650,000 strong, in Washington, D. C. In April 1993, we will march again in Washington, D. C.

I've heard it said that the National Commission on AIDS is too good on the issues. Isn't that odd? Too good on the issues! I've heard it said that the positions that you take are too far from what the White House and what the people who work daily on Capitol Hill really want to hear, so that they can't hear you any longer. You are too activist, you are too out of the mainstream. And I just want to say, if this is true, congratulations. Because you are probably doing the right thing. And I urge you to tell those folks on Capitol Hill, who feel like they can't hear you any longer, that they are just going to have to listen. Because, like us, you will have to tell them that you will not give up, you will not shut up, and you will not go away.

I thank you very much.

MR. KESSLER: Well, thank you all very, very

much.

We have about ten minutes for some discussion. I would ask that the questions or comments be kept brief, and that the responses be brief, too, so that we can hear from as many people as possible in that ten or twelve minutes.

Mr. Goldman.

MR. GOLDMAN: Thank you.

I'd like to ask all of you a question, and some of you have different capacities that you're here in, then, maybe you can look at from that perspective.

Eric and Richard talked, and all of you have talked about some of the many gay and lesbian communities that you come from, and talking in terms of the pluralistic sense of it. I know that we just spent a time with the Native American Communities, and I found a tremendous diversity even in the states of Minnesota and South Dakota that I went to, much less the states of Oklahoma and New Mexico and Arizona, that other members of the Commission went to. So we are talking about many diversities.

Is it possible, from an administrative or political sense -- and, in that sense, perhaps I'm addressing Marjorie Hill and Paul Davis in their positions with the municipal government -- to deal with that kind

cacophony of different kinds of voices and different kinds of communities? Can you -- I mean, can you deal with all of those differences and effectively use the very limited resources that are available? And, from a political perspective, Sue Hyde, can you deal politically with all of these different cacophonies without some kind of unity between them, and does that unity deny the individuality that Eric and others of you have spoken to?

DR. HILL: Good organizing, in my opinion, takes into account diversity. The reality of our society is that we have lived a lie, a lie that we are one culture, primarily one religion, with primarily one family type. It is not only possible, although very time consuming and a difficult job to be inclusive, but it's necessary in order to reflect what is, in fact, a realistic picture of society. I'll give you one quick example:

Education that is not multi-cultural will not prepare our children to deal in a pluralistic society, which is the problem, so that it will take a lot of time to develop good multi-cultural education that is inclusive of African-American, Native American, lesbian and gay history, women's history that is truly something to be proud of. I mean, it's going to take more work to do that, but that is our task and that is our responsibility.

In terms of how I personally try to deal with it, is, that, I try to find the common threads between the communities, between the different representatives from the communities, and promote those things which we, as a community, or communities, plural, can agree upon. Those things that we cannot reach some type of consensus are not unimportant, but they are things that in government we may not be able to address today.

MR. DAVIS: In response to your question, even in terms as I explained the very diversity, if you look at America, as a whole, there are various cultural issues that one has to deal with to reach various populations. Once you even look at the black community, you are talking about a great diversity. Then, if you subdivide the gay community -- in other words a poster that shows a black person talking about AIDS, the drag queen or the transvestite may not identify with that person, and say: That's not me. Well, the person who simply says, "I have sex with men, but do not call me gay," they don't identify with that. So, you are talking about a very diversified group of persons and that goes the full gamut of the community, that somehow or other you have to reach and begin to realize this does affect you.

I think is a mistake we made early along in this whole thing, that we put groups together and said

this is the information. And people said, "That's not me."

MS. HYDE: I think there are two processes going on. One is an intercommunity process of cultural development. I'll just call it that, for lack of a more precise or economical phrase.

The other process that is going on is how persons of a minority sexual orientation are understood and then dealt with in law and policy. Just as the phrase "race and national origin" includes people of many races and national origins, the phrase "sexual orientation" includes many manifestations and expressions of sexual orientation -- including, by the way, heterosexuality. It's just that heterosexual people are not generally discriminated against on account of that.

So, I don't think that in creating law and policy the point is necessarily to unify the cacophony; but, rather, level the playing field.

MR. KESSLER: Belinda Mason.

MS. MASON: It is good to see you Eric.

I want to thank all of you. This has been so good for me. I've been listening to a four-year old for about eight months and it's just wonderful to hear smart people talk about, you know, important things.

My question is, for Richard: Maybe you know

at the First National Commission on AIDS Hearing, we had Willy Beetlevon (phonetic) from Arizona?

MR. LA FORTUNE: South Dakota.

MS. MASON: And he spoke about his experience of being a young Indian man, who lived with AIDS in a very small, close-knit, extended-family sort of community. His experience was incredibly negative and horrible, in that it almost brought everyone in the room to tears. I think it's real important for us to keep hearing stories like that. That's the only thing that's ever going to personalize this thing. I mean, I could sit up here today and rattle off to you the names of 21 people that I've been close to in the last three years who are gone now. I could probably take five extra minutes and tell you who it is for me to live with it, and you would know it in your heart.

But, I was really wondering about the -- his family was very religious and they were Roman Catholic. And you touched on this some, but I wish you would elaborate a little bit on the influence of the Roman Catholic Church on your traditional mores and values and your cultural expressions, and particularly the impact that it had on sexuality, and whether or not you found that your culture was affected in affected in a different way than other cultures.

MR. LA FORTUNE: Do you mean my particular nation or native people in general?

MS. MASON: Just your nation.

MR. LA FORTUNE: Well, I looked at my watch, when I finished my last couple sentences, and -- or my colleagues -- and I really couldn't say anything more because I had already gone over by about a minute and a half, or so. And I didn't get to talk about homophobia in the native communities.

It's very severe, especially in light of our traditional history. It's not uncommon to hear stories like Willy's. There are pockets of people, and sometimes they are fairly large. What Paul was saying about the black church, sometimes you will feel the vestiges, the residual of the traditional beliefs, when you see and hear people say: Well, can you play the organ? Can you do what you're asking us, in stopping someone else from living in the expression of their lives?

The effect of the Catholic Church, I can't speak to that specifically because I wasn't raised with a Catholic Church around me. I was raised with the Protestant Church. As far as teachings about sexuality, or the lack of teachings about sexuality, the feeling of sexuality means something really quite bad, has been and continues to be, especially in light of the rise of

charismatic and fundamentalistic expressions of Christianity. It has a very, very damaging effect upon many of our peoples across this continent, and in other parts of the globe.

MS. MASON: Thank you.

MR. KESSLER: Any final comments?

DR. HILL: There was a question that Commissioner Allen asked earlier relative to what can be done, and I think that it's very important that a multitude of voices are heard in terms of gay and lesbian issues. Until we are able, as a society, to address the issues of difference in a compassionate nonjudgmental -- which, you know, sounds a little fundamentalist, when I started to say it. But I think it's really important that that is part of the goal: to hear the voices and not make the judgment.

The Commission, by virtue of having this panel, I think is interested in the diversity in the community. The decisions that are made unilaterally about health care and housing, and how national spending is made, you know, Congress and the Senate makes those decisions. They make them for everyone. I think the issue of how inclusive, or how representative our national and sometimes our local bodies are, is a question that is raised not only by the lesbian and gay community, but by

many people-of-color communities across our nation. So, I think we make, those of us in many positions, make those decisions. Sometimes, we make them with a lot of information; and, sometimes, we make them with a little bit. I think that the more information that we have, the better the decisions will be.

MR. KESSLER: Harlon.

MR. DALTON: Actually, I've been thinking about Don Goldman's question about whether, once you take seriously diversity and the range of experiences that people have and ways in which we lead our lives, whether it is possible to have a kind of coherent policy. It occurs to me that one thing that policy needs to do is really reflect one of the things that Eric said at the beginning, and try to define community, gay community, bisexual community.

He said not only are we talking about culture, not only are we talking about lifestyles, but we are talking about creating a safer world for people who fall within this definition of community. Because, in fact, as Richard pointed out, gay, bisexual, these are just sort of artificial kinds of divisions anyway, and people have to work within them because they are thrust upon people. Every individual's own situation is infinitely more complex, and that's true for straights, as

well as gays, if we use those divisions. But, what's important is to use public policy in a way that creates a safe space for people of a whole range of sexualities and life experiences. I mean, that the take-home message from this panel, it seems to me.

MR. KESSLER: Eric.

MR. ROFES: In response to that, I think it's really important to look at, in terms of AIDS prevention and services, that until the government sees a role supporting the creation of those diverse communities, understanding that we will not halt the spread of HIV among gay male youth until we've done something quite separate from HIV prevention, to make this world safe, this nation safe for gay male youth, that is the critical message. I think that linkage had to be there. We have kids in the schools, out of the schools right now, who feel horrible about who they are. Even if they get wonderful sex education courses, they hate themselves because this country, and the policies of this country, have not given them a place to feel safe and comfortable being who they are.

So, I think part of your message, I would counsel you, needs to be just as understanding the ethnic minority community empowerment as essential in insuring their health. This is where it gets real political and

that's your job: insuring the empowerment of lesbian, gay, bisexual communities of all this diversity is essential in protecting our health.

MR. KESSLER: Well, thank you all very, very much. And, on that note, we will adjourn until 1:15 this afternoon in this room.

(Whereupon, at 12:00 noon, the hearing in the above-entitled matter was adjourned, to reconvene at 1:15 p.m., the same day.)

A F T E R N O O N S E S S I O N

1:15p.m.

MR. KESSLER: The next panel we are going to be dealing with is The Response of "Sexually-Identified" Communities to the HIV Epidemic. And the order of presenters will be: Mr. David Barr; Paul Bonenberg; Jerome Boyce; followed by Vali Kanuha; Mr. Jose Perez; and Dr. Maxine Wolf.

So, why don't we start with David Barr. And I believe you each have about five minutes. If you go over that in a large way, or significant way, I will use my prerogative to cut you off. So, we really want to engage everyone as much as possible this afternoon in this dialogue.

*oooooooooooooo*DR. OSBORN: As I said this morning, I apologize for the five-minute constraint, except that it does allow us to interact and get a chance to draw you out on some issues of particular interest to the Commission. So, we appreciate your putting up with that kind of really tough time constraint.

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The Response of "Sexually-Identified" Communities to .oc1 the HIV Epidemic

David Barr Paul Bonenberg

Jerome Boyce Valli Kanuha, M.S.W.

Jose Perez Maxine Wolfe

MR. BARR: I'm really going to try to stick to it so that we can -- I think the open discussions are really helpful.

I am David Barr. I work at the Gay Men's Health Crisis in New York City. Before that, I worked at Lambda Legal Defense Fund, and I'm a long-term member of ACT UP, the AIDS Coalition to Unleash Power in New York City. I'm a gay man. I'm HIV-positive.

I'm the first person today who is identifying as openly HIV-positive, the first speaker. I just want to say at the outset that I think it's really important that we are always here, that we are always out front; and that, whenever possible, we publicly identify as HIV-positive because our voice has got to be right at the front of the line.

I'm supposed to talk about the response, and I will talk from the response of a sexually-identified community, and like what's -- I have to put some limits on it. I can talk about the community that I come from, which is middle class, white gay man in New York City,

which has very little to do with San Francisco or anywhere else.

DR. OSBORN: We know that.

MR. BARR: Yes.

Paul and I just had an interesting conversation about helping to organize a candlelight vigil in New York. I said, "We don't do that in New York." There are reasons for that. Our response is different than it is in San Francisco. Not better, it's not worse, it's different.

I think the most important thing to say about our response is that we are ten years into the epidemic. Eight, nine years ago, you know, we said we have an understanding -- we are beginning to have an understanding about what this disease is and how it is transmitted, and how we can keep it from being transmitted. Our community developed ways to prevent HIV infection from being spread. And we said so, and we discussed it, and we put it out there in the open, and we said to the country: If you don't discuss this openly, this infection will rage.

Now, you know, we are approaching 200,000 cases. It's ten years into it. We were absolutely right. And so much of this disease could have been prevented worldwide. The U. S.'s responses to this epidemic has had

an effect worldwide on spreading this disease. The policies that we developed, or didn't develop, caused the spread of HIV infection, caused it. And the reason why we developed those policies was because of who was getting sick at the outset.

Because of the homophobia, the policies were: we can't talk about this. We can't talk about the way these people have sex. We can't discuss this openly. We can't talk about it to our kids. Well, those kids are 18 to 25 now, and they're dying. So, it's murder. Because we knew what we could do; and because, because of the prejudice and fear, we didn't do what we were supposed to do. We said it would happen, and it happened, and it makes me mad.

The community that I come from is more middle class than many other AIDS-infected communities. There is more money around. There is some more education. So, we were able to respond.

You know, I was going through figures. The New York Times in June/July 1981 put out the first article: Rare cancer seen in 41 homosexuals. So those were the first supposed AIDS deaths. They weren't the fist AIDS deaths, you know. They were the first AIDS deaths among a middle class white population so they were the ones that got noticed. But once we -- once it was

noticeable to us, we began to respond. Within two months, within four weeks of that article coming out, Larry Kramer pulled a group of people together in his apartment and said, "What are we going to do about this?" And the organization began.

Because we knew from the outset that the government wasn't going to come in and say: What are we going to do? We've got a potential epidemic on our hands. We've got to figure out how it is transmitted. How can we support the people who are sick? How are we going to provide services? How are we going to create education programs? Because we knew that wasn't going to happen. Because the whole -- because our very beings were illegal in most of the states in this country, and our families disowned us -- not mine. You know, we knew that there wasn't going to be a societal response that was going to help us. So we had to respond on our own.

Immediately, we were able to create support networks to help people deal with this emotionally. Client service networks, to get people benefits and access, you know, to help them with their insurance problems, get them doctors who were going to be sensitive. Immediately, you know, we began to try to develop some education programs to get people information about this. And we became the AIDS experts. The whole concept of

safer sex came out of our community. And the concept of developing a community-based organization that could provide services and support and education for people about HIV infection, and people with HIV infection, came out of the community.

You know, we were fortunate enough to have the money available to have a private fund raising base to create these organizations and to provide some services. It wasn't enough. It's never been enough. It should never have been up to us to do it by ourselves, but there was no other choice. And we created those structures, and I think we did a very good job of it.

If you look at, you know, those cities where the structures were most successful, and the education programs were most successful, at least among that group of self-identified gay men, we saw the infection, new infection rates decline. In this city, they declined dramatically down to zero, to 1 percent.

So, we were right about how to prevent the spread of HIV infection. It worked. But was it taken on? No. Instead, instead, the government did everything that it possibly could to prevent us from getting that message out. And it wasn't just Senator Helms, though he was certainly a good instigator. But every person in Congress, and in the Senate, who voted in favor of the

Helms Amendment, you know, is responsible for all of the HIV infection that spread throughout this country after that amendment was passed.

Imagine having a disease that is transmitted sexually and the government doesn't allow sexually-explicit education materials to be put out. How can that be? Now I sit back and I think: How can that be? How can it be that I can't use government funds to teach people to put on a condom? I can't show them a picture, you know, if it's two men standing together, because I'm promoting homosexuality. Instead, I should be not allowed to do that and allow them to get sick and die. That's the message. And the message -- like, how can that be that it comes from this incredibly pervasive fear and hatred of who I am? You know, who I choose to have sex with? And not even who I choose to have sex with, it isn't even that. It is the fact that I say it, all right?

Sue brought up the Army policy, the military policy. What was amazing about the Perry Watkins Case, the most amazing part about the Perry Watkins Case, was that the Army was not -- the Army's policy, the military policy, wasn't that he should be thrown out of the military because he had sex with me, right? It had to do with -- and the court case was around the fact that he said he had sex with men, not whether he did it. And, in

fact, the policy said: Well, if you were caught having sex with another man, and you were drunk, or you were -- I swear this is in the policy; I swear it's there -- you were drunk, you said, "Well, I was curious," or "He talked me into it," then, it was okay; you can stay in the military. But if you say, "I'm gay," and you don't have sex, they can throw you out. So, it's just the fact that you say it that has cost the lives, you know, of ten of thousands, eventually millions, of people in this country, and tens of millions of people worldwide.

Yet, in the fact of all of that, right in the face -- and that's, you know, sort of like you look at it on the federal level, how could they do it; you take it to a state, to a local level, take it to every job site in the country, you know, the pervasiveness of homophobia and the effect that it had on people being able to just access AIDS information, how can it be? You know, because of the homophobia, you couldn't fit in your high school class, your health care class, and say: I want to know about AIDS, because that tagged you. If you were interested, if wanted to know, then, you must have been doing something wrong, you know. Then, you must -- Oh! You must be gay. He's asking the question.

MR. KESSLER: We're going to have to come back to you.

MR. BARR: All right. Well, give me two more minutes, minute and a half.

(Laughter.)

MR. BARR: One more minute, okay? I was going to keep it short.

Because there is an important piece that, in addition to the response that we created in providing services to our own, we also had to respond in a political way. And that is what ACT UP is.

ACT UP said: I am an HIV-positive person. I am not going to let you ignore me. You can try to ignore me, but I'm going to lay down in the street, and the agent of the government, the policeman, is going to have drag my ass off and put me in jail; and the court is going to have to deal with me. I will not be made invisible. I will be dealt with. And, in doing that, we have changed the way drugs are researched and approved in this country. We have changed the AIDS agenda, and we have changed the way -- we have helped to change the way that the country deals with AIDS. So that political response has been essential, and I think has been successful; but, God! do we have a lot more to do.

Thank you.

MR. KESSLER: Thank you.

Paul Bonenberg.

MR. BONENBERG: I am Paul Bonenberg. I have been a gay activist, since 1975. I am now currently working in AIDS activism. I expect to resume gay activism once we've dealt with the AIDS issue.

I think it is important to understand that the activism of a lesbian and gay community dealing with AIDS comes from prior activism around lesbian and gay issues and civil rights issues. It needs to be viewed in that context.

I am the executive director of Mobilization Against AIDS, which is the oldest AIDS lobbying group, political group, in California, and that has been involved in all the major political battles around HIV and AIDS, including the ballot initiatives in this state, since that time.

I think it is important to understand a couple of things about the lesbian and gay community when AIDS first hit in 1981. The most important thing to understand is that it was a political community. To be a homosexual -- there have always been homosexuals -- that is not in and of itself, a community. It is when you say, as David said in the military, or at some other position, I am homosexual, or I am gay, it is at that point you are making a political statement. This is a community that is defined of people who make a political statement. If they

don't make that statement, they do not identify themselves within the gay community, necessarily. It is when you say I am gay, and take out all the political ramifications of losing your job, of being attacked, of having judicial/legislative things done to you, that is when the gay community comes into existence.

It is important to understand that in the context of AIDS. Because that community, when AIDS hit, knew two things, basically: One was that we were oppressed, and there were great civil rights dangers. There was a collective memory, institutional memory, that went back to when people were given lobotomies, when people were given electroshock treatment, when lists were kept of people because they were gay. There was also an institutional memory that said: We can do something about that, but we have organize politically. So AIDS struck a political community in the United States, which, of course, was the worse thing for the lesbian and gay community. I also admit it was one of the best things that could have happened for the planet, as a whole, to try to respond to defeating this virus.

The response in the community in '81, I think, and in most communities, first was denial. Part of that was because that gay people died, or were allowed to die, or were killed in 1981, and it was not a surprising

thing. I mean, Harvey Milk, for example, who had been assassinated only a year or two earlier in this city, and the killer had been basically set free. Gay men were being killed often throughout the United States. It was not an unusual phenomena.

So, the idea that gay people would be allowed to die was not surprising in 1981. What was inconceivable was that hundreds of thousands of gay people would be allowed to die. That 50 percent of the whole population out of the gay communities, out of the gay men, would be allowed to die. That was inconceivable. It couldn't be comprehended for a few years. We were in a state of political denial about what the statistics meant.

Then, when the whole issue of grief -- grieving is normally the first thing that occurs, once you get past the denial. Often, that manifests itself in candlelight memorials, which often is the first organizing thing a community does, where they say we have something to grieve about here in Altoona, or here in Manila, or here in Warsaw; and that's the beginning of political organizing, as it was in San Francisco, New York and Los Angeles in 1983, when the first candlelight memorials began there.

At a next stage, generally what occurs is political organizing, and, with that, the attendant anger,

where people understand they really do mean allowing hundreds of thousands of people to die. This enrages the community, brings unity to the community, and allows people to move forward. The assumption on the other side, what we encountered on the other side, was the hate foe the people who were being struck by this disease simply for who they were. There was unequivocal hate from the very moment organizing began. There was never any doubt that there would be hate, but there was. You could not walk into a legislative office in 1983, 1984 or 1985 and not be immediately assumed to be a homosexual; and, therefore, at least a political liability, if not outright opposition to everything this legislator believed in. That was an immediate assumption when you were trying to organize around this disease.

The result of that was that there were attacks, civil rights, attacks immediately, using AIDS to attack the civil rights of lesbian and gay people. One of the first issues was the bathhouses. We don't like gay people, let's stop where they have sex. We will shut down bathhouses. That debate divided the community. Ultimately, in some cities, bathhouses were shut; other cities, they were not.

An interesting footnote to that debate, I think, is that there now should be statistical evidence as

to whether or not there was benefit to shutting the bathhouses. In other words, if a city did shut, there should be a drop in new infections; if they did shut bathhouses, perhaps there would not be a drop in new infections. Or, you can compare cities that did versus cities that did not. But, in any case, we are now far enough away from the first civil rights battle of 1984 to ascertain what occurred around that. Was it a correct health decision? Or, was it, in fact, civil rights issues?

A number of the old-time activists, dealing with the collective memory of the community said: They are trying to gather lists of us. They are trying to oppress us. We remember this from the '50s. Don't trust them. Many people, new to the community, said: That's not true. You are being hysterical. The doctors are our friends. Don't worry about it.

Ultimately, the civil rights people, I think, proved to be correct. There were ballot initiatives in California to quarantine people. There were two quarantine initiatives in California, one in '86 and one in '88. There was also a mandatory testing provision put forward that was endorsed by the Republican Party and the governor of the state of California. All of those were ultimately defeated principally, in fact

overwhelmingly, by the lesbian and gay community that was based in a whole civil rights framework.

I think that, had it not been for the collective experience of the lesbian and gay community around civil rights, you may well have had in the United States mandatory testing, mandatory reporting, and possibly even further punitive actions up to and including isolation for people with HIV. I think that we do not have that is, in part, because of the political experience of the lesbian and gay community.

Just to conclude, the other side of the organizing community was not civil rights. It was moving forward. One thing the community had learned was: the first thing elected officials tell you is: it can't be done. Because, that's what they always say when you deal with the issue of quality for lesbian and gay people. It can't be done. The second is: Well, we'll deal with it later. And the third issue is: Trust us, we'll take care of it.

The response that the community had learned was: There are no friends like us actually up there pushing for it. That translated into the politics of AIDS. It put people with HIV infection in positions of power. They are the only people ultimately who are as good a friend, as we are ourselves. It is a direct

translation from what the lesbian and gay community learned in terms of elective lesbian and gay elected officials who were putting openly lesbian and gay people in power.

That issue of empowerment of a patient is unique, I think, in the politics of medicine in the United States. It comes directly from the experience of the lesbian and gay community in terms of empowering its own people.

I think the response of the lesbian and gay community to AIDS is unique because of its political nature, because of it's past history, and was extremely beneficial to this country. The communities learned one thing, I think, many things around this; but one thing in particular: There is a greater need for coalition, that isn't just the lesbian and gay community that is suffering a great tragedy; but, obviously, AIDS is striking many other people throughout this country and throughout the world. That type of coalition needs to be strengthened.

I think, in 1979 and 1980, there was, perhaps, not as great a recognition of the social responsibilities that one community has to another; that to achieve and increase biomedical research for AIDS, we now need to increase biomedical research for all diseases. To achieve health care, we need national health care. To

achieve equality, we need broad-based equality for all groups of people. That was a theoretical construct, I think, in the late '70s.

In the early 1990s, it's reality. It is clearly understood by all AIDS activists, and I think most of the lesbian and gay community, that the battle is interlinked with these other struggles in the most fundamental life and death sort of way. I hope that is something that we will build on to defeat this virus as we go into the '90s.

Thank you.

MR. KESSLER: Thank you, Paul.

Jerome Boyce.

MR. BOYCE: Thank you.

I am very happy to be here today to speak to the Commission because I am concerned about policy. I think the Commission's job is to influence policy, talking directly with Congress and working with the president.

Our policy makers and decision makers and funders usually view HIV infection in minority communities as something that is new. It's not. Our community has responded to this epidemic for a long time. Sexually-identified communities are very diverse, especially in communities of color. This diversity has been spoken to earlier today, and I think it's something that we must

really understand, that we cannot deal with HIV in a vacuum.

Issues linked to our daily living, issues linked to who and what we are, are too important to look at in a vacuum. The strategies that we must adapt to reach communities of color, and especially the African-American community, must no longer be based on models that are not based within a cultural content and the cultural norms of our community. So often as I do HIV work, I'm in a dilemma. Because the strategies that are approved and funded, and the priorities set, are not those of my community.

I hope you are following me on this. Because, it is very important that we understand that we must change our priorities and deal with it from a holistic approach. HIV affects the whole person and impacts us everyday.

How have we responded? We responded with denial. My community, African-American Community, black gay men, HIV infected, living with AIDS for over seven years, we have responded with denial, still. It has a lot to do with my community and how they respond to a lot of things. It's been very slow. The strategies that we have come up with to deal with this epidemic have not been funded. When they have been funded, it has been

minuscule.

I live in the state of Michigan and it's very progressive on paper. And I must say that, on paper. Forty-seven percent of the people living with HIV infection are black and live in Southeastern Michigan, 47 percent. Yet, we do not get the state dollars. Yet, we do not get the federal dollars. They are given to people who cannot work with our community in a culturally confident way. That boils down to racism.

People need to understand that the policies that you make and suggest today, and the priorities that you make and suggest today, are very important. Holistic is the word. We cannot address AIDS if we don't deal with unemployment, self-esteem issues, sexuality, human sexuality, understanding the full ramifications of that.

So, these are things that I would like to leave you with today. We deal with this, as a community, despite our own internalized homophobia. That's been the biggest barrier to AIDS education in the African-American gay community. Our own internalized homophobia, the homophobia that exists within our community, as a whole and as in the African-American community, it very rampant. So we must deal with that. But we still, in spite of all that, have chose to respond.

What I would like to say is: We can only

combat this denial with real programs, with real programs that ideally, from a culturally-sensitive, culturally-competent base, deals with the whole person. Think about changing our priorities. Think about funding people on the base of need in our community. Think about reviewing these policies in a context that these are communities that have lots of problems, and we must address them all. People who are fatalistic, by their life experience, find it very difficult to understand education for HIV. It's just one of many problems that they have in their lives. So, I think we need to really look at priorities. Priorities, I can't emphasize that enough.

Local governments do not respond on the same level as our national, unless you mandate it. And that's a job that you can do in policy. Let the dollars reflect the epidemic. If 47 percent of the people in Michigan have AIDS and they are African-American males, I can't see why we can't receive at least 25 percent of the dollars in that state so that we can address the issue. I think we need to look at it in a different context.

I hope this is not viewed as divisive. Because needs within all people- of-color communities are high. We must look at them maybe with a different criteria. Our model has been wrong. The concepts that we put forth, as how we would judge something, the criteria,

is not always appropriate for our communities.

We still choose to respond. We need to be developed. And I say that as a black gay man who is HIV infected. Our community needs community support. We also need community development to respond in a way that we can be a lot more capable. This comes from within us, from empowerment. But it also comes back to our government's commitment to our community. I'm a taxpayer. I'm a state resident. My community is in financial trouble. I think I am entitled to my state dollars and my federal dollars for health care. It doesn't happen. That's policy.

Thank you.

MR. KESSLER: Thank you, Jerome.

Valli Kanuha.

MS. KANUHA: I guess I'd like to start by publicly acknowledging the gratitude that will be from everyone in this room, and around the world, to the gay male community for their efforts around stemming the HIV and AIDS epidemic in this country and internationally. As we talk today and spend this day talking sexual identities and sexual orientation, and talking about how it interfaces with issued of HIV and AIDS, we cannot at any time we talk about this epidemic forget to owe a tremendous debt of gratitude to the gay male community. Whenever we talk about HIV and AIDS and mobilization and

community organization, and changing the policies and thoughts, and hearts and minds of this country, and internationally, we must owe that debt to the gay male community.

I want to start by saying a couple things in response to the speakers from this morning. You know, what we've heard throughout the morning is a lot about the complexity of human sexual behavior, and also about the language by which we communicate about it. And many of the speakers, as well as those of you on the Commission, have asked some questions around this issue of labeling. And there are a couple of things I want to say about that.

The labels of gay, bisexual, lesbian and heterosexual -- I hope you all know, from this morning, and at the end of this day -- refer not only to sexual acts, but also to the thoughts, the fantasies, and all the parts lifestyle that really define what a cultural and a community really is. These labels, gay, bisexual, lesbian, heterosexual, in terms of the AIDS crisis, have been responsible for our finest and most creative programs and policies, and those same labels have been responsible for the greatest drawbacks in terms of doing something about the epidemic.

With regard to HIV, as a sexually-transmitted disease, we have been stymied in developing

effective strategies to stem and to curb HIV due, in my opinion, to two major reasons: The first one is the repressive and oppressive and phobic beliefs and subsequent policies about sexuality in general. I think that was articulated very well this morning. Secondly, the assumption of heterosexism and the implicit assumption in heterosexism of male and female sexuality as the primary or only means of sexual expression. In other words, if it was totally okay and right and good that you could be all that you are or desire to be as a sexual person, the labels that we've created to include all who are not primarily or only heterosexual in their fantasies, thoughts of behavior, would become merely descriptive, if not hopefully celebratory. And the values that we attribute therefore to sexual behavior, and to those communities of people who so identify with that behavior, would also be part and parcel of a diverse and rich society.

Regarding HIV and AIDS, we would not then be so concerned about special programs or policies for a Hawaiian man, who is heterosexual, but has occasional sexual intercourse with a bisexually-identified man, who himself is sexual with a lesbian. We wouldn't care about those kinds of terminologies. We would instead remember what we have learned over the last few years about HIV and

AIDS, and that is: Anyone can contract HIV by engaging in unsafe sex; and that we would target all of our strategies equally and creatively to lesbians, to occasional heterosexuals, to men who have sex with men, to everyone, to all of us in this room, who consider ourselves people who are sexual beings. We would not be afraid of transsexuals. We would not be afraid of cross-dressers. We would not be afraid of lesbian youth, who must sell sex to heterosexual men. And we would not be afraid of the gay leather community. We would not be afraid.

So, in spite of all of those political and social obstacles, what have sexually-identified communities done to respond? I'd like to focus on two communities: the gay men of color and lesbians.

Gay men of color, or men of color who continue to contract HIV through homosexual contact, are still disproportionately represented in HIV and AIDS statistics. Unfortunately, due to racism, the white gay male community has been remiss, has been slow, has been not accountable to their gay male brothers in providing the correct kind of attention, money, support and comfort to gay men of color who are dying of HIV and AIDS all over this country and internationally. And, in spite of that, gay men of color all over the United States have been organizing in their communities, among their friends and

loved ones, to develop innovative policies and programs to address issues for gay men of color. But that's very slow, and slow in coming. I hold the gay while male community on notice to be responsive to your gay male brothers of color. To communities of color who are primarily heterosexual men and women, or heterosexually-identified men and women, who are doing wonderful AIDS work, I hold you on notice to include gay men of color in your programming, in the leadership of your organizations; to look at homosexuality, to look at homophobia in your institutions, and to remember that the same way the white gay male community is not exempt from the racism that is endemic in the rest of society, communities of color are not also immune from homophobia, and we are responsible for addressing those things.

Lesbian have been involved with events through our history: the labor movement, civil rights movement, and the anti-war movement have included lesbians in leadership throughout. And, in this crisis, lesbians have been very active again in policy making, in nursing our gay male brothers through the crisis, in developing programs to deal with this issue. However, one of the things that happens is: in the lesbian community and among lesbians, there is a sense that we are immune from HIV infection. This is something, I think, is again due

to the invisibility of lesbians as women in this society, and lesbians as second-class citizens in the gay male community. It's only been recently that the gay community has used the collective term "gay and lesbian community." And because that is so, lesbians often find themselves in a position of not taking this epidemic very seriously in terms of their own risk. So, lesbians are involved in the work and lesbians need to be more attentive to their own issues, their own protection.

In closing, what has been the impact on American society in terms of what sexually-identified communities have done over the last ten years? There are three things: I think we are responsible, gay men, lesbians, bisexuals, all of us who have pushed up against heterosexual norms and the heterosexual imperative in doing three things: the questioning the assumption of the heterosexual imperative, which is that heterosexuality is the norm and the best and the right and the only.

The second thing I think we've done is: we have celebrated a diversity of sexual expression, which I think you've heard all morning today, and, hopefully, this afternoon.

The third one, which has been an unfortunate result, I think of this epidemic, is: We have built wonderful coalitions across very diverse lines of

communities and institutions, from church groups to women's clubs, gay men and lesbians, and we have brought activism -- thanks to ACT UP -- back into the streets again. It took HIV and AIDS for this to happen. It took a mobilization among the gay and lesbian community for this to happen, and society is now changed. It will never be the same again.

My charge to all of us is: Let no more of us die because of who and why we love.

Thank you.

MR. KESSLER: Thank you.

Dr. Perez.

MR. PEREZ: I'm not a doctor, but I'd like to thank the Commission for letting us, you know, participate here and share our concerns. This is something that is of great importance to me, and is a great part of my life. I'd especially like to thank Eunice Diaz and her efforts in our community to make AIDS something to talk about. That was a very important effort.

I'm a gay Latino person with AIDS. I am cofounder of the National Latino Lesbian and Gay Organization. Currently, I work at AIDS Project, Los Angeles as a public policy specialist.

What I'm going to do is, is I am going to

try to describe where the Gay Latino Community emerged from and how it was impacted by AIDS; and, then, how we impacted the Latino community in general.

Throughout the '60s and '70s, openly gay Latinos migrated from rural areas in Puerto Rico and the Southwest, and sometimes Latin America, to large urban centers throughout the U. S. Half of them, half of the U. S. Latinos had dropped out of high school. The thing -- when we got to the cities, the thing that kept us together and apart from the other gay and lesbian community were our culture, our language, and our socioeconomic background. Those were the foundations for our community to stick together and strengthen itself.

When we found ourselves in the city, we created extended families, based on our social, cultural and socioeconomic backgrounds. Later, we created organizations around those extended families, with names like The Gay Chicano Caucus in Houston, Gay Hispanic, United Gays and Lesbians in New York, the Colectivo Gay in Puerto Rico, and Gay and Lesbian Latino in LA, just to name a few.

These organizations were soon challenged by AIDS, and they had no one to turn to. Gay and lesbian white organizers considered us separatists; and, therefore, we had no help from them. The Latino community

was very homophobic and couldn't see what our existence was about. The way -- the first thing that happened to our community, when we confronted with AIDS, was that we were very afraid and we had a tremendous amount of denial and a lot of us turned to substance abuse -- a large proportion, just from my own circle of friends, and from stories and people that I've heard, because we have no data on that. We continue to deny "it," and hoped that it would go away.

Finally, our friends started getting sick, and it was overwhelming. It was overwhelming that extended family members, and there was hardly any help. We started taking care of them, but we had a fantastic fatalistic attitude that said that we could just help them die. And that's what we did.

Finally, our organizations started to react. We reacted in many ways. The gay and lesbian, the political groups, they started education campaigns; and, then, other gay Latinos broke away and started AIDS service organizations, particularly in the Southwest. Gay Latino AIDS service organization, with roots in the Gay Latino Community sprang up in Houston, Austin, Tucson, Los Angeles, San Francisco, and they did it all through volunteers and fund raisers. We did prevention programs, safe sex workshops, with not a cent from any governmental

agency, from no foundation, from just fund raisers, selling tamales, selling drag shows, et cetera. That's what we had to do because there was no response from the government or the existing AIDS service organizations.

This exhausted our community. And it continues to exhaust us. We continue to not get any help. And we continue to be there polarized because of our culture, because of our language, because of our socioeconomic background, a part from the gay community, and part from the Latino Community. Finally, we carried that message to the national level through the National Latino Lesbian and Gay Organization, which also has received little support from any institution or governmental agency.

The impact of our community, Gay Latinos in the U. S., responding to AIDS on the Latino Community has been that we broke this myth that Latinos would not talk about sexuality when it came to a life-threatening disease. Through various methods, we discovered that it was the clergy, it was the elected and nonelected leadership, and others, business leaders, who kept that message from reaching our community. I don't say that as an indictment, but I say that as a fact: there needed to be more response early on.

We continue to struggle to keep the doors of

the Gay Latino AIDS Service Organization open. Some people will say that it's too specialized. But, in cities like New York, where there is 10,000 Latinos with AIDS, it's another story.

Finally, there is dozens of Gay Latino bars throughout the U. S., dozens of Gay Latino restaurants, and newsletters, publications, small as they are; but this is still not enough proof for even the gay community that we exist and that we're centered around our culture, language and socioeconomic background. As long as that happens, as long as that exists, we're going to be denied the attention that we need to our needs from both communities, the Latino, as well as the gay community. We are stuck in that Catch-22: Who do we belong to? Unfortunately, our sexuality that we adopted from the dominant gay culture doesn't mix well with our Latino culture, and that creates an issue.

Thank you.

MR. KESSLER: Thank you, Jose.

Maxine Wolfe.

MS. WOLFE: Hello.

I want to speak as someone who has been an activist the last 30 years, working in different types of social change movements, as a lesbian, part of the time having to be in the closet in those movements. I want to

start with a little story.

You know, as fascism took hold in Germany in the late '30s, and laws against Jews were being written legally in Germany as the basis for the eventual plan of extermination, Jewish-Americans got together and they tried to petition Congress to change the immigration laws in this country, which had been passed in 1921 and 1924, on the basis of research that proved conclusively and beyond the shadow of a doubt that Eastern Europeans, who were primarily Jews, were feebleminded, sick, and should not be let into this country. As a result, when Jews wanted to get out of Europe, those laws were the barrier in saving their lives. And in speaking to people in other political groups, they told the Jewish-Americans that they had better get Christians to speak for them. Because, otherwise, people would think that we were too selfish and had a self-interest.

I have always been a person who has disliked the use of holocaust imagery and its application to the AIDS crisis, especially as a Jew. But I feel that some parts of that are extremely apropos, and that's one of them.

Basically, lesbian and gay men have been active in every political movement that has ever existed. And in all of those movements, they have been told to stay

in the closet, and they have been told to let other people speak for them. Because, if they did come forward, everyone would think that we were selfish. And the AIDS crisis has been exactly the same. I think it is very important to remember that.

Our response politically has been quite diverse. In fact, it started with actions against the closing of the bathhouses in New York -- and I speak to someone from New York. It continued to demonstrations around the Supreme Court supporting the sodomy laws. Eventually, then, ACT UP, which is what was just said, what Joe just said, as those people said: We are tired helping people to die; we want to help people to live. And that is not a put-down on the service organizations, it's just meant that people had discovered that, unless we acted politically, all we could do was to help people to die because no one was doing anything else.

In the wake of that, groups like ACT UP, and other groups, started doing a lot of political work. And every single bit of political work we have had to do, we have to confront the twisting of the results of that in terms of the concept of our special interests, and the homophobia that was connected to that. So, as David said, when we made comic books, they took the money away and said we were promoting homosexuality. That

heterosexuality is promoted every day and in every way in this country is something that no one ever seems to get hold of. But it is something I want to say clearly: we could not possibly promote homosexuality to the extent that heterosexuality is promoted.

We went and did our own research and we started getting underground drugs in here to save people's lives, and people started passing laws to prevent us from bringing drugs in. Every single step of the way, we have been told in everything that we have done, we have had a barrier put up in front of it. So, it's very hard to believe that someone does not want all of us dead. And I am not a conspiracy theorist, but it really gets hard to keep my eye on where I'm going when that keeps happening.

I want to talk also about the issue of lesbians. Not only have we been active in every service organization, but in every activist organization. And every time we have raised the issues of the possibility that lesbians could transmit HIV or be people with HIV, people laugh at us; they laugh at us. James Karnes, head of the CDC HIV Surveillance said: "Do lesbians have sex?" This is the man who is responsible for doing the epidemiology in this country in which no one has ever asked a question about woman-to-woman transmission. And that is partly because we cannot talk about sex. The CDC

epidemiology is still about risk groups and not about behavior; and, therefore, cunnilingual behavior, for example, does not get recorded and has not been recorded. And any work that we have had to do in the lesbian community to tell women that they may, in fact, be engaging in behavior that is risky, and it may be sexual behavior with a woman and not with a man that is sex that is risky, we have gotten no research done on this, no response to it at all. So, I hold the government, and anyone who does not speak out about it, personally responsible for the death of any lesbian who contracts HIV through woman-to-woman sexual transmission.

I also want to say that the things that have been discussed today, that we are a diverse community, but we have to compromise that. We are intravenous drug users. Lesbians, the majority of original cases of lesbians with HIV have been intravenous drug users. And, like any other oppressed community, any kind of substance abuse is higher in those communities partly because people are oppressed and it's stressful and they look for ways out, and partly because the people who benefit from that hang around the places that we are forced to go because we cannot be out. They hang around bars, for example, and give people what looks like an easy out to the stress. So we are intravenous drug users. We are Black, Latin,

Native American, Latino. We are a diverse community.

When people talk about outreach, it is always as it everyone in the gay community is white and the outreach is out there. Instead of, that we are that diversity, and because people frame things that way, it is very easy for people to pit one community against one another by acting as if we have no overlap. So I think that's another thing that's clear.

I want to say, also, that every time we have had to fight for our lives, people tell us that we're not fighting for the lives of others. So, I want to tell you just in a very quick list some of the things that ACT UP -- which is always perceived as a gay white male organization, middle class to boot, when, in fact, it is not -- are doing.

We have a Latino bilingual forum that we do on the lower east side for people in the community about HIV. We are just finishing a women's treatment agenda, and I've been working on women's issues for a long time. We have a needle exchange program. We are doing work on national health care. We are doing work on insurance issues. We are doing work on condoms in schools. We have produced a housing organization for housing for homeless people. We've produced an AIDS treatment registry to list clinical trials for everybody. That has been mailed out

all over the country.

This is not just work that has been done for the gay community. It has been work that has been done for everyone. And, in fact, one of our own problems that comes from self-oppression is, that, a lot of gay men came into ACT UP to hide behind AIDS, since it was easier to be out there doing work about AIDS than to be doing work as gay people, because of the homophobia in this country. And one of the things that was very good about the response of the gay community through activist groups like ACT UP, and it's not the only one, has been to give people a place where they can be both gay and people working on the AIDS crisis, and to be proud of both of those things.

I want to end, also, with another anecdote.

When the Quilt came to New York, I was one of the volunteers that opened up the Quilt in their panels. And one of the people who did that with me was my friend, Oliver, who died this year. And the end of opening the Quilt, when you get to the last panel, there is a blank panel and you can write whatever you want. Oliver wrote: I will survive. And, I'm not even -- I'll finish this. And the next day, I said to the pin -- that's a pin that used to be prevalent in the lesbian community; it's a double ax that's a lesbian symbol. Underneath it says: We will survive. And Oliver didn't

make it.

I would prefer that the policies you pass make it possible for us to survive. We will survive, anyway. Somebody will be here to bear witness.

(Applause.)

MR. KESSLER: Thank you very much.

Commissioners, do you have questions, comments? Belinda?

MS. MASON: I want to thank all of you. It's good to hear you. It's good to hear that some people are doing the Lord's work in spite of everything. David, I'm glad to meet you and see you here. I heard a lot about you. You certainly have lived up to your reputation.

(Laughter.)

I have a few questions, in particular, for as many of you all that would like to take it on, about how it has been for organizations which were primarily funded and organized, who has black, male, middle class community. I was pleased to see on the bio sheet here that Valli is working at GMHC and doing a lot of work with children and women and prevention, and things. I'd like to hear you tell me, first, David, about the difficulties that you all experienced when you tried to transfer GMHC's programs to children, women of color, heterosexuals, and IVD users. I mean, as many as you will would like to talk

about your experience in that way, I'd like to heat it.

MR. BARR: The difficulties have been many. GMHC, as the community-based organization that was founded by a particular community, was best suited to work with people from that community. As the epidemic grew -- but because that community had this, had some money, our responsibility had to be broader. And, as the epidemic grew, or our knowledge of the epidemic grew, it was necessary for the mission of GMHC, and the people that we serve, to be broader. And that has been very difficult.

Right now, our client base -- we have about 4,500 active clients right now; and we provide education for thousands more people -- our client base fairly accurately reflects the demographics of AIDS in New York City, which a fact that is not well known, unfortunately, in terms of our racial and gender breakdown. What I don't have are statistics on the socioeconomic status of those people.

We had to make certain decisions. We decided that we were not going to be able to serve active drug users as clients because we weren't equipped to deal with, you know, a much broader array of issues and services that that group of people needed, that we weren't a drug treatment center. We didn't know how to do that, and that wasn't the area we were going to move in.

We acknowledged that the way that we hired people and trained people was going to have to change drastically as the demographics of our client population changed. Sometimes, we are more successful at that than others. We realized that our educational programs had to be -- we had to develop different kinds of educational programs targeted and created by different groups of people; that an education program that was for the African-American Community had to be created by African-American people, and was going to look different than the ones the white gay men got. Some of that has worked better than others.

I think there is another piece, which was an acknowledgement that we were not going to be able to serve everybody. That it was inappropriate for us to think that we could. Not just because of the size that we would have to become to do that; but, because culturally, it doesn't really make sense. So, what we've done is help other community-based organizations in other areas of New York get started by providing training, technical support, money, and by using like our resources -- you know, we got a policy department of eight people. Now there's community-based organizations in New York that have eight people. So, one of the major roles of our policy department is: as we work on issues, to always work on

those issues, in coalition. Now, it's a part of my job is to always to make a lot of phone calls and bring people in so that we can use those resources to make sure that there are a lots of voices sitting at the table when we are talking to the mayor or the governor, or you all.

So, that's sort of how we try to do it. It is really -- it's just really hard, you know; nobody's ever happy with it on any end.

MS. WOLFE: Can I say something about it?

I would say, you know, that part of the problem there is their should be, given this epidemic, there should be 10 to 12 organizations like GMHC in New York, in all the different communities, of that scope, and maybe we'd be somewhere. Now, part of that issue that, in some ways, any organization that managed to get formed early on ends up being given the primary responsibility. Because, instead of the resources growing, you know, as the epidemic has become apparent to everybody else, and that's being spread out so you could have large organizations. You know, it doens't happen; it doesn't happen, and it's so necessary.

I mean, there's an organization in New York, which is called WARN, which is Women AIDS Resource Network, that struggles to survive, struggles, struggles, struggles with the enormous number of women infected. And

this not being any resources, given -- it's not a matter of taking away and giving it. It's a matter that they should be as big.

MS. MASON: Valli, I'd like to hear you talk a little bit more about the work that you do at GMHC, and what kind of barriers you encountered, you know, in trying to develop program that were geared towards, you know, different kinds of people with AIDS, in particular people of color, poor people, women, kids.

MS. KANUHA: I'm no longer associated with GMHC. I'm working at the Hettrick Martin Institute for Gay and Lesbian Youth.

You know, I don't know that I have anything more to add from what David has said. I think that there's a very difficult tension in terms of the established AIDS organizations around this country, in terms of, again, their original mission and the communities that really are the foundation of their work. And for many of them, of course, it's the gay male community. I think that what we want is what Maxine said, she said: distribution of resources so that many different communities can develop programs that are appropriate to their, to their culture and their lives.

MR. KESSLER: Thank you.

Harlon, and then Don.

MR. DALTON: Well, I'm sort of torn about pursing this, in part, because the issue for the day is to try to bring to visibility sexually-identified communities and AIDS. And, also, as I was saying to Belinda in a little note, I think I probably have a reputation at GMHC bashing, which is not real well deserved; but I do want to pursue this for just a moment.

David, I was struck very much by this sort of candor and thoughtfulness of your answer to Belinda's question. Something you said, though, stuck in my mind when you said: We made a decision not to serve active drug users because we didn't have, among other reasons, we didn't have the expertise. I was struck because, when this Commission first site visit, we visited Whitman Walker in Washington, D. C., and we were told much the same thing: We don't have monies for people who are drug users because we don't know anything about those problems. And, one answer would be: Well, then, you get people who know something about those problems, or you develop some expertise. That wouldn't be an answer for some other homosexuals, and say: We don't know anything about gay problems; and, therefore -- so that's the sticking point.

On the other hand, half of people, half of African-Americans with AIDS, half of the Latinos with AIDS, are men who have sex with other men, and they tend

to be very much sort of forgotten and hidden. It could be that the decision is just flatout: Listen, we're going to focus on sexual transmission of this disease, or gay -- not that's not a respectable decision. The problem is, though, with saying what the problem is, is that there needs to be greater allocation to other organizations. The problem is: that's not happening, hasn't happened, isn't likely to happen.

So, I guess the way to frame the question is: What do you see as sort of the obligation, if any, of those who were first through the door, who partly -- largely funded on their own, that is, by their own community. It's not necessarily that that the federal government of the state or the cities are going to lavish money on you; but, nevertheless, who are in a position of having, as you say, eight people in your policy department. This is a conversation that we have all the time with Larry because of AIDS action, and he may want to weigh in on it. But, I guess -- and the answer, it is a respectable answer to say, well, you know, we have a moral obligation, but we have enough to do just dealing with our initial mission. But that's at least the question I'd like to hear.

MR. BARR: One piece of the answer is -- I don't think that the answer is -- I've been there since

August.

(Laughter.)

It's not enough to me. I mean, that answer just isn't enough. I think -- one of the ways that we are attempting to deal with it -- I don't think we can become a drug treatment service organization. It's too big, it's taking on a whole other piece of work that we really are not well equipped to do.

But what we are equipped to do, and we've just -- actually, we're bringing somebody on staff in the policy department in the next week who is going to look at substance use and harm-reduction issues. And what he is going to focus on is looking at all of the ways the drug treatment is provided in New York City, help to advocate for more drug treatment, and look at the HIV-related issues that come up there, and provide those drug centers with HIV expertise, which is what we have; and, in reverse, bring to us some of the substance use issues that will affect, you know, our clients.

We have a lot of clients in recovery, gay, straight, you know. So that's one way that we're trying to like make an inroad with this. Because, it's like to take the expertise, it's to learn as much as we can about the issues and see how it affects what we do, and to also bring our expertise outside and help them, and to work on

creating more services. Again, it's still not enough, but it's one piece.

We also have come out publicly in favor of needle exchange programs and other harm reduction activities, and have actually helped to fund the needle exchange program in New York City.

MR. DALTON: Don, did you want to say something about this before I ask the question?

MR. KESSLER: No, I don't think I can add much to that. Except that it is an ongoing dilemma and it's because, in my case, we may possibly do serve people who are active addicts. I may mean, however, that we will have to cap clients sooner than later, and then that will become a problem across all communities. Because no one else in the city wanted to serve active addicts. We did do it, but it will probably, within the next year, that active addicts, gay men, people of color, will have to go on a waiting list because we can only do so much for so many at one time. GMHC also had to do that in spite of limiting populations.

MR. GOLDMAN: I have a question.

In preparing for this hearing and reviewing some of the materials, it is clear that there is a long historical, well, let anybody use the word, but let's say not necessarily a good relationship between the gay and

lesbian community on the one hand, and the medical community on the other hand.

My question to you is: How has that impacted on -- how do you look at the future and how things ought to be, given AIDS and what we now know about AIDS and HIV infection, and has that less-than-happy relationship been good or bad? Should it be improved? How has the community responded? I was wondering if any of you would want to comment on the issue in general, particularly looking from the perspective of how things ought to be down the road, in the future, rather than focusing on the past?

MR. BONENBERG: If I could comment?

I think, actually, it's interesting. I don't think that there has been, at least in California, I don't think there was a traditional hostility between the lesbian and gay community and the medical community. I don't think there has been particularly a hostile relationship. I think that, to some degree, the medical community, at least medical people I work , are not used to be criticized at all. Within in the lesbian and gay community, there is such intense criticism within the community just to connect the contact between the two groups led the medical community to believe that they were being severely criticized or attacked. I don't think that

was so.

Remember, at least within California, there was already openly identified gay physicians, who immediately took on patients, who were immediately regarded as heroes very early in the epidemic. Then, there were the researchers who were the allies to the activists, going in lobbying elected officials, whom were funding. I think, by and large -- and, of course, with LaRouche and Dannemeyer initiatives, it was the medical community that moved forward, almost alone, in support of the lesbian and gay community to defeat the civil rights attacks. I think, in this state, there is a very high regard for the medical community, and certainly for specific medical practitioners who were regarded as heroes within the community.

It is interesting to often have a discussion where people are responding to what they consider to be general attacks, or great concerns. I think the medical community, however, has had a sense of political naivete that, if they could just be left alone to run the epidemic, there wouldn't be these problems, and why were gay activists interfering. I think it was clearly shown that they, the medical community, was underestimating the threat coming from the far right. The gay and lesbian community were correctly anticipating it. At some point,

the medical community said: Gee! There really is quarantine on the ballot. I guess they weren't -- I guess there were some civil rights concerns after all.

I would think that what will occur in the future, what should occur in the future, is a strengthening of that connection. One of the places that connection will occur is lesbian and gay, openly lesbian and gay physicians and researchers, and certainly openly HIV-positive physicians and researchers, and those people, I think, will again serve as the bridge between the two different communities.

But, I must reiterate, I disagree with the historical assumption that there's been animosity between the two communities. At least in California, I don't think that's been the case.

MR. BOYCE: Being from the Midwest, I have a different perspective. Being an African-American, I have a different perspective, and I must say this.

That for African-Americans to go to the doctor, and, if they haven't been shot, they don't go. So, having a good relationship with a doctor is something new -- Okay?

(Laughter.)

I must say that, you know. African-American gay men don't go to doctors. You know, it's just

something we don't do culturally. You have to be very middle class and trained to go to doctors. It's the last priority. You know, it's nothing that you wake up and say, "I need to go to the doctor." Also, if you go to a black doctor, he's liable to be homophobic.

So, what we have done, as a community, is to respond to the epidemic, we have actually went out and trained black nurses, who will be the first person you see, who will give you an attitude and you won't want to go back. We've learned to sensitize them about issues of sexuality and AIDS. These are the sorts of projects that were funded through Howard University.

There has been several things that we have done as a community. When I say "denial," it is a real factor in our community. We deny everything that we can't cope with; and AIDS, we definitely can't cope with.

So, we are working. We want to respond and we want to do a better job. We have some great ideas. I think that, if we could be given the proper funding to follow through on projects, we could make it. That has nothing to do with GMHC and large group. That has to do with our rights, as human beings, living in this society, that pay taxes, don't get a fair share of our tax dollar. And that's not to take from their group, but to advocate for more of our rights.

Health care is not a given in this society. I wouldn't be alive to day if I didn't have a compassionate doctor, and learned how to hustle to get to a doctor, too. I had to use my street skills to get there. And it's very important that we realize that health care is just not the same. Even if you have a job in the country, health care is not the same. It requires a lot of care to manage HIV. It requires a lot of treatments to manager HIV. They're expensive for everyone. And if you have money, eventually, you will be broke.

So, it's something that we need to look at: why we need this extra help and this extra support, because our communities are not accustomed to facilitating doctors, making decisions around health care. So, we are running seminars to inform people -- this is a community response; no federal dollars -- seminars to inform people about clinical trials so that they would know how to access clinical trials. A lot of one-on-one education goes on in our community because that's the way we learn; that's the way we learn best, one on one. When those programs are not acknowledged, when those programs are under funded, and those programs are left to fall to the wayside because they might not have the management skills necessary to run a project, instead of supporting that

project's management aspect, that project is usually closed.

So, we have to realize that we do have some deficiencies we need to work on, but we also need a lot more support. Because, we come from a culture that is different. We must acknowledge how diverse America is.

MR. DAVIS: I would like to focus on what Jerome was saying, because I have to leave and miss your next session on policy.

I think one of the big issues is the question of funding service for the community of color. That's were the numbers are greatly increased. I know in LA County, where Black and Latino persons represented something like 20-some percent of the cases five years ago, they are now pretty close to 40-some of the cases. In terms of women and babies in the black community, in the Latino community, those numbers are increasing and the largest numbers.

And it is some of the problem, hearing agencies talk about nine people in policy, when I don't have nine people I can put on the street to do health education. That's how I educate the homeless people in LA. It's not by TV, it's not by ads. They don't see those things. There priorities are immediate problems. It's a matter, also, that they don't have money for

condoms. That's not in their budget.

The other problem is: a lot of community-based organizations, like ours, the Minority AIDS Project, right now, we can't even afford to accept more money, even if you gave it to us, because most of your contracts require us to pay the money upfront, and then get reimbursed; and, a lot of times, we wait two and three months to be reimbursed. And the monies that we raised, in terms of fund raisers, like our Coming Home for Friends last year, we spent $65,000 of monies given to us through donations and fund raisers to feed people, to house people, because no other programs do that.

In the Latino community, they can't get Social Security, general aid Social Security. Who is going to pay their rent?

Those are the issues that we're dealing with.

MR. KESSLER: Jose, I will give you the last work, and then --

MR. PEREZ: I just wanted to voice a concern that, I'm -- the fact that a lot of doctors, because of homophobia and AIDS-phobia, don't shy away from AIDS. This is especially important in the Latino community in East Los Angeles, where we don't have, you know, doctors who are knowledgeable about HIV, for detection, or

intervention, or anything. And programs, such as the USC AIDS Training Center, have tried to train doctors, and they have a hard time keeping them there, for many reasons: economic and time, and also there is a lot of homophobia and AIDS-phobia. And, in Los Angeles, 80 percent of all Latinos with AIDS are homosexual/bisexual, and they know that, and they know that that's what they are going to deal with.

So, I mean, AIDS Project Los Angeles, and, ultimately, East Los Angeles Health Care Corporation, who serves Latinos, we're working to find a way to bring in third-party payments, and the USC Training Program, and everybody, so that we can get some of these doctors to stick to it and give them some sexuality training, and stuff, and in the HIV training, and they will be ready to respond to their community as it happens. But I have a strong feeling that a lot of people that are getting AIDS now, gay men of color, women, et cetera, aren't going to be comfortable in traveling to West Los Angeles or the Valley to see doctors in that area.

MR. KESSLER: Well, thank you very, very much, all of you.

We will take a break and resume at 3:05.

(Whereupon, a brief recess was taken.)

MR. KESSLER: This afternoon's session will

be on the topic of "Sexuality, HIV and Government Policy." The order of presentations will be: Tim McFeeley; Carmen Vasquez; Dan Bross; Miguel Gomez; and Tim Offutt.

We will start with you Mr. McFeeley.

Sexuality, HIV and Government Policy

Daniel Bross Miguel Gomez

Tim McFeeley Tim Offutt

Carmen Vasquez, M. S. Ed.

MR. MC FEELEY: Thank you, Mr. Kessler.

DR. OSBORN: This is a high-class --

MR. MC FEELEY: Larry is a high-class kind of guy.

Thank you all very much.

My name is Tim McFeeley. I am the executive director of the Human Rights Campaign Fund. Through lobbying, political activity and constituent education and mobilization, the Human Rights Campaign Fund has a mission to secure legislation and policies at the national level that protect the health, safety and civil rights of lesbian and gay Americans.

It's certainly a privilege to testify before this commission, and I appreciate the opportunity to do so. I'd like to take a moment just to commend the Commission Staff for its fine preparations for these hearings. I'm really impressed. Thank you.

We've heard, earlier, how American society thinks about sex, sexuality and sexually-identified communities. We've also had the benefit of testimony from leaders of the lesbian, gay and bisexual communities, and learned how these communities have responded to the HIV epidemic. Let me also say it's a privilege for me to be a member of that community.

At this time, at this place, the 1980s and '90s, in the United States of America, I'm really proud to be a member of the gay, lesbian and bisexual community in terms of all they're doing, in terms of the safety, civil rights and the health of our community.

Just as the American society denies the natural existence of homosexuality and bisexuality, most Americans continue to deny the existence of AIDS, the threat of HIV, and the inadequate public health response to the epidemic, a full decade after the first identified and reported case. And although, today, the Commission is focused on the nexus of society's views towards sexuality and our national response to AIDS, I'm compelled to note that a similar denial reflex operates, with respect to racism and sexism in America, that also profoundly affects our lack of response to AIDS.

This attitude of denial pervades the government's response to both lesbian and gay civil rights

issues and to AIDS policy. Society's denial of the natural existence of homosexuality and bisexuality results in the view that an individual chooses a particular lifestyle, rather than has a particular sexual status. Flowing from that view is the notion that choices have moral, religious and personal consequences that are the responsibility of the person making the choice. And, as a result, society, as a whole, and its government, take no responsibility for the consequences of these choices.

In the civil rights arena, the combination of denial and irresponsibility by our society means that America benignly accepts discrimination, allowing employers to fire people, for example, because they are lesbians or gay men, and often promotes discrimination, as in the case of the irrational Defense Department policy that excludes gay and lesbian Americans from serving in the Armed Forces.

In the arena of health care, the denial, irresponsibility syndrome produces an acceptance of HIV infection among gay men, while we hear our national leaders make distinctions between "innocent victims of AIDS," generally infants and those infected by blood product, and the rest of the HIV universe. Because Americans still see HIV disease as the consequence of choice, they do not feel morally responsible for its

devastation. Unlike polio, tuberculosis, or influenza, all infectious diseases that have been controlled by our public health system, and which provoked a sense of communal responsibility and empathy with those unfortunate who have become infected, HIV disease provokes a hostile reaction for those who have the disease and towards those who are gay and are therefore more likely to contract the virus.

Obviously, as Commissioners, generously donating your time and energy toward the effort to improve our national response to the HIV epidemic, you are all individuals who have taken a large measure of responsibility. The general problem, then, is to replace denial with acceptance, and to substitute responsibility for blame. Let me note a couple of specific examples that we at the Human Rights Campaign Fund have experienced:

The most glaring is, perhaps, the censorship of educational and preventive efforts directed at gay men. By denying that men have sex with other men, and that the use of condoms and other sage sex practices can slow down the spread of HIV, Congress and the administration condemned thousands to die. Similarly, the denial of teenage sexuality, both gay and straight, prevents the government from helping schools and other agencies to provide condoms, and instructions in their use, to kids

who will die as a result. Also, every time an AIDS authorization or appropriation bill is debated, we are obliged to fight people who would deny clean needle programs, or even simply the distribution of bleach to disinfect needles, in order to maintain the fiction that addiction involved choice, and that giving people clean needles encourages drug abuse.

What kind of irresponsible, irrational morality is operating in opposing simple public health policies to contain viral infection? Often, the opposition is led by the presumptive morale leaders of our society, such as the archbishops and TV evangelicals, who promote a public morality that is grounded in denial and results in death.

Confronted by a society that denies the natural existence of homosexuals and bisexuals, and that takes no responsibility to control the viruses that afflict them, referring, instead, to blame the victims, it is understandable that the gay community is terrified, angry and demoralized. While community oases have been discovered to do what they can to stop the spread of AIDS and to care for those living with the disease, the public panorama for all HIV-infected people, and especially for gay men, is a desert of denial and resulting devastation.

What is needed is education not only about

HIV itself, and how it is spread and how it can be detected and treated, but massive education about the topics we've discussed today. We need to shock America out of its state of denial. Whether they like it or not, Americans need to know that men have sex with men, that women have sex with women, that some men and women have sex with both men and women, that teenagers have sex, and that people will not stop having sex; but they can be taught to have safe sex. Whether they like it or not, America needs to wake up to the fact that intravenous drug use is a fact of life in the United States, and that clean needles are better than dirty needles. There are many facts that Americans must know. Our enemy is ignorance, and demagogues that thrive on ignorance and fear.

I, and the people I represent at the Human Rights Campaign Fund, believe in education, change and progress. I know that the Commissioners and your staff do, as well. Americans are quick studies. They can learn fast. Please, please, give them the facts about sexuality and about AIDS and all of us, not just the gay, lesbian and bisexual community, but all us, would be much better off.

Thank you.

MR. KESSLER: Thank you, Tim.

Carmen Vasquez.

MS. VASQUEZ: Thank you, Commissioners and staff for arranging this day.

I am Carmen Vasquez, and I am the coordinator of lesbian and gay health services in the City and County of San Francisco.

Before I start, I'm going to promote a book. It's by John Emilio and Estelle Friedman, "Intimate Matters, a history of sexuality in America." Any policy maker, any educator, anybody who cares about this topic, needs to read this book. I brought it today because their introduction includes -- has a quote from a song by Cole Porter:

"In golden days, a glimpse of stocking was looked on as something shocking, and now, God knows!, anything goes."

That was 1934, and Cole was an optimistic sort of guy.

(Laughter.)

Because, the fact of the matter is, that, you know, the progression of sexual liberation, which a lot of us wants to think is on this sort of line that goes up, in fact, is not on a line that goes up; that it goes up and down, and sometimes gets buried, depending on the economic conditions of the country, the status of the family, and a whole lot of other things that I don't need

to get into here.

There's a lot that's been addressed today that I'm probably going to repeat. But, before I do that, I want to try and summarize what I have heard, at least, as two essential messages that most of the people on the panels today have been trying to deliver.

One is, that the effective prevention, surveillance and treatment for HIV is not possible; it is not possible without an affirmative challenge to the sexual mores of our society and broad, broad promotion of education on human sexuality, all human sexuality.

The other thing that we've been saying is, that, effective prevention, surveillance and treatment for HIV is not possible without government policies that affirm, facilitate and protect the empowerment and civil rights of lesbians, gay men, bisexuals and communities of color in this county.

Without those two pieces being in place, I assure you that the possibility for this country to really make an indent into the spread of HIV is going to be significantly affected for the worse.

When I was invited to speak, I remarked to -- and I'm sorry, I don't remember who it was that made the actual invitation; but I said to him: Perhaps nothing is more American than wanting sex, dreaming about sex,

commercializing sex, selling sex, idealizing sex, and never, never, never talking about sex. And I really believe that. It's not just in the Latino community of the black community, or in communities of color, but it's also true in white suburban communities.

I'm sure that there have been people before you, or that you've been at hearings where folks have come up and talked about the outrage of sex education in the schools, talked about the outrage of erotic art of any sexual orientation, against the distribution of condoms, et cetera, et cetera. And, what I want to emphasize is that, you know, American attitudes toward sexuality, such as the host, they exist; but, at the same time as those people are saying those kinds of things, their kids are at home masturbating to Playboy or Penthouse, getting pregnant at 15, and getting gonorrhea at 16. There is an enormous gulf between what people say that they want in terms of a morality about sexuality, and what they really do.

We have a very schizophrenic attitude about sex. We say it's sacred, we say it's evil. We say it's romantic, we say it's trash. Sex sells everything from mouth wash to cars. You know, people tell their kids you are not even to think about sexuality because it's bad, or it will get you in trouble; and, then, you know, they have

their kids sit through the family hour and watch those gorgeous bare chested men selling clothes, or terribly sexy women that are stroking red cars. Sex is everywhere and sex is taboo.

You know, I obviously don't have time to get into why read the book, and I'm not going to get myself in trouble by blaming the puritans or the Catholics; but there is an historical basis to the sexual mores that dominate our society and that rule government policy. Some of it is not off the wall either. When a society, ages and ages ago, didn't expect to live past 35 years, it kind of made sense to promote reproduction. When we knew of no way of curing syphilis, it made sense to kind of, you know, tell people that they shouldn't be having sex with anybody. And we might have kept Mozart around a lot longer if we could treat syphilis.

But those material bases for the kind of sexual mores that exist today, and that government policy is still based on, don't exist anymore. A woman doesn't have to get, you know, near 500 miles of man to get pregnant anymore. People don't have to, you know, die of syphilis. People don't have to die of gonorrhea, and people don't have to die of AIDS. That's just a fact. The unfortunate reality is that our scientific and technological progress is way, way, way, way ahead of our

social evolution and of the sexual mores that dominate our society.

So, you say, well, why is it that we remain so ambivalent, and why do we cling to values and myths that have no logical basis in material reality? You know, again, that's another lecture, and I haven't got the time to deliver.

I think the important point about what I'm trying to say in terms of sexual mores, government policies, and historical basis for them, is: the governments, our governments, ancient governments, governments all over the world, different types of societies, have always had an interest in regulating sexuality and controlling reproduction, in codifying sexual mores that will hopefully keep people from getting diseases that will kill them. In our society, we haven't reached the point where we have understood that the people who make government policy, that the educators in our country, that people who are parents, that just about anybody in this country, is not immune, is not immune to those sexual mores and to what they dictate to us about our openness and sexuality.

In the case of -- you know, that's sad but true. In the case of AIDS, that's tragic and true. That we have had over 100,000, over 110,000 people die of a

disease that is entirely preventable is tragic. That government policy makers bow to pressure from conservative constituents, who don't want sex education in schools, who don't want condoms distributed in jails or schools or advertised on television, or even talked about -- for God's sake! -- because government policy makers don't want to deal with their own fears, with their own mads, with their own outdated, irrelevant, useless and often hypocritical sexual mores. I think that we should not mince words, we should not mince words, when we advocate for what will prevent AIDS.

These are the kinds of things that I think we must be willing to on the record as saying. Get over, get over sexual mores that don't work and have no meaning in our society anymore, or be responsible for the continuing death toll of HIV in our society. We can't contain the spread of AIDS without talking about sex. We can't talk about sex without understanding and confronting those deeply embedded and contradictory messages that we all have received about sex and sexuality.

I honestly believe that no one, no one, no program in this country, should receive funding for AIDS prevention without also receiving resources to address the issue of sexuality as a central component of their programs: Sex, in all its wonderful possibilities, and

sex, in all its sordid possibilities. But, before that kind of policy can be created, government policy makers need to stop being so squeamish about a human activity that they engage in, and love to engage in. They need to accept the reality of what has been repeated here many times today: that there are men and women, in all communities, who will never, never, never, never say I am a homosexual. I am a lesbian, I'm gay, I'm bisexual, because they fear the condemnation of society, because they fear losing their jobs, because they feat losing their kids. And, still, those people regularly, sometimes, often engage in high-risk sexual activity with other men, with other women.

They need to accept the reality that adolescents are hormones on legs, and they want sex, look for sex, will have sex, no matter what. The school board, their parents, their teachers, their ministers, or anybody else, has to say about it. They need to accept the reality of bisexuality for both sexes, of lesbians who sleep with men at high risk, of intravenous drug users who will shoot up with any needle available and who also have a sexual life.

The bottom line is: If we are interested in saving lives, then, government policy on HIV has to be guided by an awareness and an appreciation for the

centrality and significance of sex in all our lives, all of our lives, no matter how tenacious our tendency may be to want to silence it.

And, we need to understand that training -- I mean, training is not all that difficult. I do training. I do training on human sexuality for health department staff. There are African-Americans that come to those trainings, Asians, Latinos, heterosexual people, lesbian and gay people, bisexual people, clerks, psychiatric social workers, M. D.s, nurses, all kinds of people come to these trainings. The trainings are explicit. I wish -- we should have shown some films we here today. Because, if you want to convey the message that sexuality is human, and that sexuality is something that we all engage in, and that sexuality is fun and a natural part of who we are, you've got to talk about it, you've to show it.

I think that every health department in this country has an obligation, if it's serious about curtailing the spread of HIV disease, to have human sexuality training for it's workers. You can't expect a doctor, or a nurse, or a psychiatrist, or an ambulance driver, whose only sense of what it is to be gay comes from the kinds of scripted messages that we receive in our society -- those schizophrenic kinds of mores I talked

about -- to be able to treat someone with AIDS in a humane fashion if they've never had a chance to talk to a person who is gay, if they've never had a chance to see what human sexuality of different kinds looks like, if they've never had a chance to read about, if they've never had a chance to be in a room where all of those different kinds of people can sit and have dialogue with each other, and deal with each other as human beings.

There are models for training that exist. They should be promoted. They should be promoted widely.

I want to just finish by saying that this Commission, in my opinion, can make no greater contribution to the struggle against HIV than to take a strong, unequivocal position on the need for sex education in the schools and in public health settings, and the need for providing all human service workers, all educators, and all policy makers with that kind of empowerment and training.

I will end with that, and thank you again for the time.

MR. KESSLER: Thank you.

Dan Bross.

MR. BROSS: Good afternoon.

My name is Dan Bross. I am the executive director of the AIDS Action Council in Washington.

To coin, or to pick up on a phrase that Commissioner Goldman used earlier, I think this morning, we work on trying to affect behavior change among members of the House and Senate in Washington. We represent in Washington some 500 community-based AIDS service organizations throughout the United States.

This is my second appearance before the Commission. I was reminded this morning that really the first time I appeared was actually before I started my job. I have been in this job now for seven and a half months, and I've come to the conclusion that, when you're working at least for a national organization, I think, probably, with a community-based organization, too, each month probably equates into a year in sort of normal work, if you will. But I appreciate having the opportunity to come here today. I really appreciate the Commission and the staff of the Commission for having the vision and the foresight to hold this hearing, which I think addressed many of the critical issues that our government continues to wish to ignore.

When I was thinking about how to present my comments today, I decided that probably a journey looking back over some of the experiences I have had, since I became involved in AIDS activities and in gay and lesbian issues, would provide you with some insight on some of the

issues that we need to discuss.

I want to take you back to 1984. In 1984, I was working in the private sector for an energy company in Houston, Texas. I was manager of public affairs. While I pinstripe suit on today, there were some differences between today and 1984. In 1984, I was a gay man, but I was safely hiding in my pinstripe suit and behind my white shirt and tie. When, suddenly, in the corporate setting, I was asked to work on a city ordinance in Houston that I felt cut to the very heart of what I considered to be basic human rights. And that ordinance was an ordinance that prohibited discrimination in employment based on sexual orientation. Unfortunately, the ordinance passed, but it was certainly the best thing that happened to me, because I came to terms with who I was and what I was, and what I believed in, and what I felt was important.

Following that experience in 1984, I moved quickly to remove some of the contradictions and incongruities between my personal and professional life and moved to California, where I had the opportunity in 1986, in July 1986, to work on the No on 64 Campaign, a referendum that Paul Bonenberg referred to earlier. It was a statewide campaign organized and funded and staffed, in large part, by members of the gay and lesbian community. It was a campaign to defeat a referendum

sponsored by supporters of Lyndon LaRouche that would have required mandatory testing, reporting, and quarantine of HIV-positive individuals.

I'm reminded, or sort of been reflecting over the past few months to back in 1986, in that ballot initiative, that referendum, we were talking then about many of the same issued that we are still talking about today in the context of the infected health care worker: talking about mandatory reporting, mandatory testing. It's sort of ironic that, while a number of years have come between 1986 and 1981, we really are still focusing on a lot of the fundamental issues that we were talking about back then.

In 1987, I moved to Washington and worked for the fist time in my work in AIDS. I got to take a proactive position, rather than a reactive position. I went to work for Whitman Walker Clinic. Jerome was talking about, on the last panel, where black gay men don't go to the doctor, or black men don't go to the doctor.

Whitman Walker Clinic, as some of you are probably aware, was formed back in the early '70s. It was formed before AIDS as a gay health clinic. I was thinking, when Jerome was speaking, one of the reasons Whitman Walker was formed was because I think a lot of gay

men had two doctors. They had a doctor that they went to for colds and broken arms and poor eyesight, and that sort of thing; but, then, they had the doctor that they sort of went to for the unacceptable things, like sexually-transmitted diseases. Whitman Walker Clinic, and a number of other gay clinics, formed throughout the country in response to that concern and that fear and that distrust within the gay community of public health officials and of the medical community.

And I hate to keep telling you where I went to work next, but I joined David and Val, actually, at Gay Men's Health Crisis in New York City. I mention that because I think it's important to look at Gay Men's Health Crisis and recognize the name. Gay Men's Health Crisis was an organization, as the name implies, that was founded to respond to a health crisis in the gay community. It was founded by members of the gay community because nothing else was being done to address a health crisis that was killing their friends and their loved ones. It was founded by a group of men who recognized and reacted to a crisis long before the government was willing to acknowledge it, or certainly act in responding to that crisis.

In September of 1990, I became executive director of AIDS Action Council. As some of you know,

that was formed back in 1984, again, by leaders in the gay community who understood the importance of advocacy and who experienced first hand the federal government's unwillingness to address a national health epidemic. That's all I'm going to bore you with sort of my personal resume.

In reflecting on where the government is in terms of responding to issues of sexuality and HIV epidemic, I want to echo something that David said in the last panel, and that is: We are ten years into an epidemic and we still have a government which will not discuss it openly. We are ten years into an epidemic that has killed over a hundred thousand people in this country, and we have a government that chooses to talk about other issues that are safer to discuss. Because, in this country, as Carmen just said, we have problems talking about sexuality. Until our government is willing to address head on a lot of the underlying issues regarding HIV infection, we are going to have to continue to face a difficult time in coming to terms and adequately addressing the epidemic.

The second point I want to make is: the government can't react to the AIDS epidemic, I feel, in large part, because who is getting sick. First, it was gay men; then, we moved to IV drug users. We are talking

about poor people. We are talking about disenfranchised segments of society. I've often commented to friends: Can any of us sit here and imagine or visualize for a minute what would have happened, what our government response would be, if AIDS would have first affected junior leaguers? I'm sure we would not have a National Commission on AIDS because the government would have responded by this time and the work would have been done. There would have been billions of dollars committed to fighting the epidemic, but the disease didn't strike junior leaguers. It struck first in this country gay men.

AIDS Action Council, while formed in 1984, I think has really sort of come into its own over the past few years. One of the reasons AIDS Action Counsel has been successful is because an issue that I'd like to talk about and refer to as inclusiveness.

AIDS Action Council, back in 1987, was involved in a group in Washington called The Second Monday Coalition, which has since become the NORA Coalition. It is because of that coalition that our federal government has been able to deal with some comfort with issues surrounding AIDS and the HIV epidemic. The NORA Coalition has brought together over a 150 national organizations, including the Human Rights Campaign Fund, in addressing the AIDS epidemic in a way that is less threatening to a

number of our elected officials.

You take the NORA coalition as sort of, if you will, the mainstreaming of the AIDS epidemic, and add on to that the very effective and fine advocacy work done by ACT UP, and we are a powerful coalition that covers the spectrum of sort of political ideology in this country. And it's becoming increasingly difficult for elected officials, both within the administration and on Capitol Hill, to ignore us. They can't go out on the streets because ACT UP will make sure their lives are miserable, and they find some of us in the halls of Congress making their life miserable.

A lot of people in Congress, who have been our most vocal opponents, are people who look at the AIDS epidemic as we against them. Bad people got AIDS; good people don't get AIDS. The concept of otherness.

We have been successful -- "we," AIDS advocates, and I include all of us in this room as AIDS advocates -- we have been successful because we have ignored that we-versus-them mind set, and, rather, have fought that, combated that, with the issue or the idea of inclusiveness. It is absolutely essential, if we are to be successful in getting our government to devote the resources that we need to fight this epidemic, that we continue to broaden the coalition of groups who are

willing to speak out and become involved in the HIV epidemic.

I will close with one comment. I was talking to a Maureen during the last break, and I had faxed from the office in Washington today an article that appeared in The Washington Post. We were talking about -- the article talks about the amount of money that the appropriations committees are going to be dealing with, over a whole range of domestic issues.

I was thinking, I mean, we're talking about dividing a very small pot of money across a range of issues and the domestic agenda that deal with health, education, housing. When is this country, when is our government, going to understand that the domestic infrastructure, the needs of our people are being ignored? When are we, as advocates, as individuals, when are we going to stand up and say we demand more money for the domestic programs in this country? I think the AIDS epidemic, it goes without saying we all agree, we need more money to effectively fight the AIDS epidemic. But we need more money to fight a whole range of domestic issues. It is essential that, in addressing AIDS, we do not lose sight of the other issues on the domestic agenda that continue to be ignored. And while we have been successful the past few months talking about the need for more money

for the domestic agenda, we cannot lose sight of the money specifically within the domestic agenda, but we need to fight the AIDS epidemic, also.

Thank you.

MR. KESSLER: Thank you, Dan.

Miguel Gomez.

MR. GOMEZ: Is there another commissioner with us now?

MR. KESSLER: No.

MR. GOMEZ: It was just someone sitting in someone else's seat, that's all. Sorry. Don't know all the commissioners by face. I was hoping there was another one.

(Laughter.)

Well, I've only had one other opportunity to talk to all you, and I wanted as many as possible.

Actually, what I want to do, because I have spoken to you before, is: I want to thank you. This is landmark. Having this hearing on this issue is landmark. You have also landmarked in, especially -- I come from the Hispanic community, the Latino community, and your effort to look at the issue of HIV disease in the Hispanic Latino community, and in particular, how it impacts the Puerto Rican community, has been a great deal of help to my community.

I work with the National Council of LaRaza, which is in Washington, D. C., which represents Hispanic community-based organizations throughout the entire country. The agency -- and I think it's important to know about the agency. Actually, for about three years, I worked at AIDS Action Council, and I actually worked at the campaign fund. So, checkered past. I like the AIDS business.

What is important about the NCLR is that two and a half weeks ago, we were in the president of Mexico's palace talking about free trade. But on Cinco de Mayo, we were in the streets with the Salvadorian community, trying to help negotiate the problems with the riots in Washington. So, I come from an agency that I think is very diverse and invested in the Hispanic community.

What I'm going to talk about in five minutes is sexuality, HIV disease, and impact on policy. And I'll try to come up with some ideas, or highlight some solutions.

One of the things I think is absolutely amazing is the harmony of this meeting. If you were to take the transcript from this meeting, I'd swear it would be a guide for the nongay community, to the gay community. I mean -- and, then, of course, I'd ask the commissioners to read it twice, reinforcement for that behavior change.

(Laughter.)

But, looking at the -- not to be flip; but actually, it is real important.

We talked a lot about sexual identities. Well, as a self-identified gay man, that is just part of the spectrum, as many people told you this morning, in the Hispanic community. But you must look at the diversity, the full spectrum.

Pepper talked about a study of the farm worker community that engaged in same-sex sexual activity, but don't identify as bisexual. Many self-identified Latino gay men live in three worlds: the Hispanic community, the Latino gay community, and then the dominant white culture. In the Hispanic community, there is tremendous norms and pressures to not identify with the gay lesbian community, and there is clearly the differences. When it was talked about earlier this morning about the difference between behaviors and identifying -- and David, I thought it was wonderful when you talked about having your lover's mother and your mother talking about their support. In my family, I am told constantly that they will pay for the wedding.

The Hispanic culture, the No. 1 problem in the Hispanic Culture is gay identification. Lesbian identification is a No. 1 negative. Homophobia, I

believe, from my experience, is our No. 1 curtails -- it curtails us from contributing to the management of the HIV disease. When I spoke to the Commission in March -- when I spoke to the Commission in March -- we have staff meetings at the National Council of La Raza, and there about 5 people at a table like this. When I sit at the staff meetings -- I'm going to speak on Hispanic issues in March in Chicago. My office colleagues applauded. I was stunned, but I was very proud.

When I -- last Monday at our staff meetings, I said I was going to San Francisco and talk about gay and lesbian issues. There was no applause, and I had to document why I came here. I am also quite proud of my agency for telling me that you should go. Homophobia is rampant.

Also, there is an emerging change. The fact that the largest national Hispanic organization did send me. At our annual conference, we have receptions for the lesbian and gay community. And there is an emerging national Latino lesbian and gay organization called LLEGO, which has been around, working with groups in the Latino community for over ten years. I'll make sure you all get flyers on this agency.

But, real, real important is the stigma is damning to a my own community. Women have had to take the

lead, like Eunice. In the Hispanic community, because they have not been stigmatized, that perhaps they may be gay, or they have another reason for working on the epidemic, a woman had to bear the brunt on setting policy. And it is real, real important.

Health care workers in our community, our doctors in LA -- we have many, many doctors: but very few are willing to work on this epidemic because of the stigma. They don't want to be identified with working with that community.

HIV in our community -- Jerome, you said it beautifully in Detroit -- it's an issue of economics and access to help, No. 1. In the Hispanic community, we are working for and we have economic issues. We don't have two doctors. And the epidemic, as you know, is disproportionately affecting our community. And that's important when you are looking at policy. And the education campaigns have to be looked at, because, for many of us, we feel that they have failed, especially for the Hispanic community. And education has to target both partners, which has been talked about before. Also, the lesbian Latino community, real important.

One thing that is also scary, which I know goes into other realms, one of the things we've done in the Hispanic community is, we've encouraged Latino women

to talk to their partners about safer sex. The CDC goes around telling us that has caused increased violence against women.

But, policies -- Okay? Miguel's solutions, ideas and thoughts.

I said homophobia was the No. 1 problem. The Latino community, they have to put self-identified gay and women up front: but they also have policies against discrimination, and they have to follow through on those policies.

AIDS service organization, which primarily are run by the Anglo community, have to look at issues of racism. Valli, at an early panel, discussed this issue when she said actually put them on call, I believe. But the real important issues -- David talked about Gay Men's Health Crisis. They did some very good things. They looked at their policies about hiring minorities, and also the way in which they trained to be effective. When Dalton asked his question, how do we answer these questions? Well, everyone can't serve everybody, but we can share our resources. Gay Men's Health Crisis can help support minority organizations, teach them how to work that money game in both the private and public sector. There are ways definitely to work together.

The PWAs, who end up being under utilized,

is astounding to me. In the Hispanic community, there is a tremendous amount of discrimination. But I often find, in my own community, saying: Is there anyone representing the people living with AIDS? I will often get the question, Why?

Also, when it comes to federal money, I think, as Dan said, in NORA Coalition, which he was referencing, was inclusive. I think it needs to expand its inclusiveness and reevaluate that issue, real important. Was really proud to see the coalition, recently and actually with Don Goldman's help, and the Commission staff, look at the issue of immigration and HIV. But, for the Hispanic community and the Anglo-gay community, we had two issues: one was immigrants trying to seek residency in this county: the other was travelers. And there were two issues, but we were able to work the Hill together.

Other issues: We need to make sure we start spending money on paying to evaluate what we're doing, enforcing that to know what works and doesn't work. We've said over and over again, we don't know who -- we know that sex sells cars, but we don't know what sex -- how to talk about behavior change within our own community and evaluating what works and doesn't work. We have a lot of research even in the Hispanic community, but it's

inadequate.

In addition, the Commission, which, again, I would like to laud for your ability to outreach. You are not like many other federally-identified entities. But I also think -- you summoned, throughout this country, to the territories, people to come and speak in front of you. I think that you can also challenge us, when you put out your report, to make sure that we carry the message that you can say. I think it is definitely a two-way street. I know that, in the future, you'll be putting out comprehensive reports, or series of reports: and I am sure that you will continue, when doing those reports, look at the impact on the communities.

Thank you very much.

MR. KESSLER: Thank you, Miguel.

Tim Offutt.

MR. OFFUTT: Good afternoon, Commissioners.

My name is Tim Offutt. I am currently the minority initiative coordinator for the Department of Public Health AIDS Office here in San Francisco, and also the assistant branch chief for prevention for San Francisco. So, I am sitting in a very unique position in terms of talking about public policy. Because not only are we, as a local agency, or government agency, I should say, victimized by federal policy: but we then have to

victimize, to some degree, our local CDOs in that we have to interpret and implement those policies.

As everybody else seems to have said, the fact that the HIV epidemic began in the gay/bisexual community, and, to a lesser degree, the IV drug users, has a profound impact in terms of how government policy makers have responded to this epidemic, or not responded, as the case may be. A decade ago, the medical community was very slow to even consider the incidence of pneumocystis pneumonia, and other rare diseases, in otherwise healthy individuals as something to be alarmed about: and, if they were concerned, it was from a purely scientific perspective. Because, after all, these individuals were "members of fringe populations." They were not perceived as part of the mainstream, and, therefore, of little consequence and concern. That perception and that feeling has continued, to some degree, to shape how this country has responded to this epidemic.

Having worked for a number of years as the executive director of a community-based organization, I know firsthand the difficulty of trying to do explicit AIDS and sex education in communities using federal dollars. We still have to deal with the Helms Amendment. We still have to deal with community standards committee. We still have to convince our funders to see that being

explicit, for example, in the gay and bisexual community is the most effective and culturally competent approach to providing education to that community.

So, the implications of how policy has been formulated in response to this disease, as others have said, have served to hamper and not to assist us in terms of trying to educate targeted populations, at-risk populations, and the general community, with regard to HIV infection. This is not to say that there hasn't been some level of progress in the past ten years; because, clearly, there has been. There certainly has not been enough.

One has to wonder if, for example, a middle-America young man named Ryan White hadn't been so publicly seen as a symbol of the ravages of HIV, if we would have seen the kind of legislation, such as the Kennedy Care Bill coming out of Congress, if we would have seen the kinds of money -- even though it hasn't been sufficient -- allocated to providing services, particularly in the under-served communities. I think we need to be real clear about the fact that those under-served communities were under-served communities prior to the advent of HIV. It has been the policy of this country not to provide universal access to health care, particularly in poor communities. HIV has simply impacted and compounded the problem. So, the monies, which were made available as a

result of Ryan White, while they are greatly accepted, still fall far short of what is needed in those communities who have historically lacked the infrastructure resourced to provide adequate health care.

I really don't want to be redundant in terms of what other people have said because, you know, I've written this wonderful speech and it's pretty much been covered by about everybody else. But I do want to point out that, if we want agencies to be effective, and I'm speaking primarily of gay-sensitive, gay-dedicated agencies, who are going to be providing AIDS education, then, we need to look at those policies emanating out of Washington, emanating out of Atlanta in the CDC, which restrict the kinds of programs that these organizations can provide to their target populations using federal funds.

Thank you.

MR. KESSLER: Thank you all. We have about five or ten minutes for comments from the commissioners or others around the table.

Anybody -- Eunice.

MS. DIAZ: The last two panels have not specifically addressed any efforts that your agencies may have regarding the protection of civil rights related to AIDS discrimination. I really would like to know -- I

certainly know GMHC has that, but I would like to ask any of current panelists, and past panelists, if you could tell us, specifically to communities of color, if your agency has any effort or interest.

MR. BOYCE: I'm with Project Survival in Detroit. From our very beginning, we started to work on legal issues. I took it upon myself to go to Chicago to address some legal issues and find out about a client that I had, who needed an operation, and he couldn't get the operation because of his blood. No doctor wanted to work with him. So, he had a heart problem. This is something that no one wanted to deal with so I knew that we had a legal challenge. Out of that, we found a doctor, who was able to treat him, and he didn't need the operation.

That taught me, right then, that the system set up, the infrastructure for AIDS legal referrals, just wasn't happening in the Midwest. So, we got a task force together and we have a group now that addresses all legal issues. This was a community response. We worked in cooperation with a couple organizations that would be called mainstream, and they wrote a few grants targeting money for the development of that. It is all basically volunteer.

So, I think the community has responded just out of sheer necessity. Most of us have a civil rights

background. I grew up in the '60s. So, you know, we had to do things about it. It was something that was a part of our culture.

Legal issues are something that a lot of poor people are very uncomfortable with, because we don't have a lot of experience in hiring attorneys. I personally went through problems with attorneys trying to deal with tax problems and property tax. I was told that, if I didn't have $300 the attorney didn't want to deal with me.

So, I knew, as a person living with HIV, that legal issues are real important to your survival, and it's a tool. I don't see a national commitment in people of color to address that. It happened in Detroit. I'm very happy about that. I would like to see it happen nationally in all communities of color because we don't have a legal remedy, often.

MS. WOLFE: Maybe I can say something about two different things that we've worked on in ACT UP, and with other groups in New York City that deal with discrimination issues. One has to do with federal housing projects.

The Brashee (phonetic) Decision, which allowed coinhabitants to keep an apartment, though it dealt with gay couples, as well as other people, does not

extend to housing run by the New York City Housing Authority projects that were federally funded. We worked with, our housing committee, worked on some actions, and then with some people, to confront changing those rules, using the particular case of two Latino gay men, one who died and his lover was going to be thrown out -- very often people forget that, you know, we are living in housing projects, too. so that's one issue.

The other one that we've been working on has been a lawsuit against Health and Human Services about the definition of AIDS and the fact that poor people, women, intravenous drug users, are being discriminated against, by virtue of the way that AIDS has been defined and the kinds of disability benefits that they've been able to get or not get, depending on that. And that's a suit that's being brought by Mobilization for Legal Services that people in ACT UP have been working on, by giving information about all these issues. They represent people who cannot afford legal services and it runs the gamut; and, of course, in New York City, because of the relationship between institutional racism and poverty, a lot of those people are people of color. They are also gay people, they are intravenous drug users, they are heterosexual women, lesbian women; it's quite broad.

So, there are a lot of discrimination issues

that we are still fighting everyday.

MS. VASQUEZ: There is one, for me, one of the biggest discrimination questions has to do with immigration status, and whether or not a person has an HIV waiver. If you are not a documented legal, whatever it is that people say, this country, the possibilities that, or the likelihood that you are going to seek medical care, are very, very, very, very low.

In San Francisco, there is not a whole lot of work that I see that's proactive in terms of HIV and immigration issues. But there are immigrant rights organizations that are doing work on the issues, and they are organizations that are terribly strapped in terms of funding that will provide legal advice to people who are HIV-positive and are not legal immigrants of this country.

MR. KESSLER: Dan, and then, Charles Konigsberg.

MR. BROSS: Just two quick points.

As you will recall, last summer, Congress passed and the president signed the Americans With Disabilities Act. AIDS Action Council and MFAR and the American Civil Liberties Union are involved in an educational outreach program now, and working specifically with targeted members of the minority communities, educating both employees and employers, as to their rights

and responsibilities under that legislation.

Picking up on what Carmen was just saying about immigration, again, coalitions is sort of a key in Washington, and working on the immigration issue, the AIDS community was part of the larger immigration coalition in Washington, making sure that Health and Human Services got the kind of input that they needed in looking at that issue. We are continuing to work with them and see what might happen on Capitol Hill in trying to address that issue again.

MR. KESSLER: Charles.

DR. KONIGSBERG: This has been one session where I've not been the only voice from the Midwest. We've had several people refer to it. It's been very reassuring.

DR. OSBORN: Charlie, I keep trying to tell you Michigan is in the Middle West, too.

DR. KONIGSBERG: That's true, Jean. That's true. You're absolutely right. I'm not sure what the Middle West is. Maybe we're trying to think about attitudes a little bit.

Let me try to broaden this title just a little bit, sexuality, HIV and government policy, and try to get this panel to thinking back, just a little bit, to some of the testimony we had earlier on the larger

question of sexuality and government policy. Let me give you a tale from Kansas, specifically, but it could be any state, really.

There is an organization known as Right to Life. It's an interesting title. And one thing I do not want to do is broaden the conversation to the abortion issue. But, when you talk about, when we talk about how government policy on a sexually-related issues comes about, in our state -- which is not a particularly mean-spirited stated, not a lot of really nasty things that come out of there are the things we have to fight off -- we are a state that has made a fairly serious commitment of state money to prenatal care; but no state dollars to supplement the federal dollars for family planning. This is a direct result not of the poverty of our state, or inability to put some money in family planning; but, in fact, is related to the political influence that the right-to-life groups have on the elected officials. This has not yet spilled over into AIDS. But it has spilled over into attempts to get family planning services and counseling to teens, and we watch this kind of play out in the legislature. What happens is that, much of what is done either is ineffective and very little is being done. So, I think we need to kind of look at that broader issue and how this relates to HIV.

MR. KESSLER: Scott.

REV. ALLEN: I've heard several people give statistics on the hate crimes that happen across the country, but I'm curious about how the bill is being played out, that was passed, the Hate Crimes Bill, and the enforcement level, and some of you folks may have some information on that, the documentation. I just don't even know what the status is of it. I thought maybe you all would have a handle on something like that.

DR. HILL: Well, in terms of New York State, the Hate Crimes Bill has not been passed. It passed in the Assembly. In the State Senate, it has been tied up in committee. We're active, in collaboration with a number of community-based organizations, to try and lobby for it. I'm very proud to say that the gay and lesbian community has really taken the lead. Unfortunately, for some state senators in New York, who view our community as being dispensable, that has been problematic. I don't know in terms of-- the Federal Hate Crimes Statistics Act does, in fact, include violence against lesbians and gay men, and it is basically documentation; and, at least in New York City, the Bias Unit of the New York City Police Department has adopted them in total, with some encouragement from the lesbian and gay community. Basically, it broadens the definition of bias so that, essentially what will happen

is that we will see a rising statistic in terms of bias violence. But, just in terms of New York State, it has not been passed.

REV. ALLEN: In other words, rather than enforcement, the implementation, how is it being implemented structurally through the country? Is it accurate documentation or not?

MR. MC FEELEY: I can't really say that the implementation has taken hold yet. I think the progress is racial. It wasn't for the -- if it wasn't for, frankly, the gay and lesbian community monitoring that, specifically the National Gay and Lesbian Task Force and their violence project, making sure that the Justice Department, and various agencies, federal crime enforcement agencies, were doing that, I think it would just drop by the wayside. It is kicking in slowly. We do know that various agencies reported and it is statistically being documented now that the gay and lesbian community is the most physically bashed community in the United States.

To quantify that further, I mean, and then to formulate some sort of prophylactic policies, or for some source of education programs to try to prevent that, I think is something that really has been left to the local governments. In some places, it's good; in some

places, it's bad.

While I have the mic, I also wanted to make one point. There is a piece of federal legislation pending right now that we all need to weigh in on. It's the Civil Rights Act of 1991, which broadens the remedies, or at least takes the remedies back to where they were before some very restrictive court decisions over the last five years. The Human Rights Campaign Fund, along with other civil rights organizations, has that on the top of its agenda not only because it's the right thing for all of us, in terms of civil rights, but specifically with respect to the AIDS crisis. It would include people with HIV disease, as disabled people, included now because of the Americans With Disabilities Act, they would be covered under the broader extension of the Civil Rights Act of 1991. That's something that is pending right now, and opposed by the president of the United States, I should add for the record, and needs everyone's support

MR. KESSLER: Any other --

MS. WOLFE: Could I suggest, say something, just to put this into perspective, and I hope you will take this constructively.

I think it is really great that we have a Hate Crimes Statistics Act. But, anyone who has been the subject of a hate crime knows it's been going on forever

and ever. The way we deter -- we don't pass hate crimes bills. We go and we collect more and more statistics. And, in a way, it's very parallel to the lesbian and gay community. We've been collecting those statistics on our own for years -- Okay? -- which nobody believes because, somehow, we did it, you know. Is it true of other communities? And, instead of implementing programs to deal with it, so much of that is connected with the way that HIV is dealt with, we get more research and more research and more research; and, meanwhile, people are getting bashed on the street and killed, and we still have to prove that a crime was a biased crime. And I think it tells you something about what the attitudes are in this country towards the validity of our experience and what we know about it.

And, in terms of New York, I want to say that one of the most amazing things that the New York has been -- the coalition that has been formed around that, has been between the Black and Latino Caucus and lesbian and gay, you know, and progressive people in the legislature. That constantly, the opponents of that bill have tried to convince the Black and Latin Caucus that they should not support sexual orientations, that they can get a hate crimes bill that deals with real hate. And to their credit, the Black and Latin Caucus has consistently

supported the lesbian and gay community. And I think that that is another issue of the way we've got to start looking at what is going on.

You know, research is great, but we've got to act to save lives, and we've also got to acknowledge where the coalitions are and who is against that coalitioning.

MR. KESSLER: Thank you all --

MR. BARR: Could we just implore you to take this information and use it and put out a report on it? It's just vital. A report on this would really be helpful for us, and really is crucial.

MR. KESSLER: Report on the --

MR. BARR: A report on this hearing, and on the issued that we've discussed today.

MR. KESSLER: Well, thank you all. We will adjourn for the public part.

DR. OSBORN: Let me suggest that those of you who have the time and want to stay comfortably where you are among our panelists, and those who have pressured schedules and knew that we were to finish at 4:30, please don't feel pinned down. But there are four people who have requested the opportunity to make comments. I would ask them to keep their comments to two or three minutes a piece. And, as I say, if you must go, we understand; but

I hope that those people will, too. Otherwise, if you just want to just stay comfortably --

The first person who has requested the time to speak is Louise Alvarez Martinez. Perhaps if you could come to whichever of the microphones is most convenient and make your brief comments.

Public Comment Period

MS. MARTINEZ: First, I would like to being by giving a very strong criticism of the outreach and publicity that has not been done in letting the public know about these hearings. I found out about it, because I have an excellent network, just last Thursday. When I started calling around to see who would be coming, no one knew about it.

So, I really want to stress that we need to know that these are happening. The communities affected must be a part of these hearings. Our concerns must be heard. It must be open process. The opportunity to personally address the National Commission on AIDS is very rare. I just really want to stress that.

I wasn't able to be here for most of the day because of that. I had other commitments that I had to keep. So, I may be repeating some things that have already been brought up, but I don't think that's going to hurt anything.

Latina women are being infected through sexual transmission by Latino men. There needs to be more reaching out and education of our community. Hidden bisexuality of Mexican-American and Puerto Rican men is common. Our communities collude in keeping this a secret -- not only our communities; but, as has been pointed out, all of the United States society. There is a tremendous taboo against homosexuality and bisexuality in the Latino culture. But this cannot be used as an excuse not to reach into our community. We are not impenetrable.

Latina women need to be educated, supported and empowered in protecting themselves from HIV infection. Our men are at high risk due to the depressed economic, social and racial climate. Unemployment is increasing and so is drug use. Our migrant population is very much at risk, and outreach needs to be directed to them. Culturally and linguistically appropriate support services need to be developed for women. There needs to be more research on transmission, especially for lesbians. There used to be a notion that lesbians did not transmit or become infected.

The bisexually-identified communities AIDS model does not address women's issues. We can no longer be left out of the conduit. We must be the ones to develop the services and outreach to our community. And

the bottom line is access to health care. We really don't have that. Of the 37 million that are not insured, Latinos and Latinas represent a large number of that. That's my bottom line.

Thank you.

DR. OSBORN: Thank you very much, and thank you for taking the extra effort to come.

In the context of others who may not have -- we did have public announcements, but it's difficult to be as pervasive as we would like. And if there are others that you know who would like to make comments, we would welcome them to write them to us, and we will try and be attentive to the input of that sort.

Thank you for coming.

The next person is Douglas Serano.

MR. SERANO: My name is Douglas Serano. I am the cochair of Gay Asian Pacific Alliance, and the former chair of its HIV Project. I want to thank the Commission for having this hearing.

Before I get down to my comments, I want to invite everybody in the room to the Asian and Pacific Islander Hearing tomorrow. Because I really believe that awareness leads to cultural competency and we are serious about talking about cultural competency. We really need to educate ourselves.

One of the first things I want to talk about is collaborative efforts. During one of the panels, in terms of the response to HIV, what was absent was the collaborative efforts that are happening within the gay men of color community.

In San Francisco, there is a Gay Men of Color Consortium on AIDS that is compromised of four ethnic groups, and they are gay organizations. The reason for it forming is, well, one is, is what Tim McFeeley was talking about: the hostility towards AIDS. But the second reason is because the hostility, because of racial hostility. So, when you combine those two, it really forces gay men of color to support each other in challenging those hostilities.

Just down the street, at 625 O'Farrell, is the EACH Program, which is an acronym for Early Advocacy for the Care of HIV. I would encourage the Commission members, and anybody else in the room from out of town, to maybe visit the offices. They are open until 6:00 p.m. and sometimes longer. It's a few blocks down. It also houses Bay Area HIV Support And Education Services, and the National Task Force on AIDS Prevention of the National Association of Black and White Men Together.

My point around this is, that, it is really important to fund gay and bisexual community-based

organizations addressing AIDS. And I don't think there is too many groups, CBOs, throughout the country, that are gay and bisexual and are directly federally funded. So I really believe that in dealing effectively with the target population, it's important to have people from that target population developing the programs, implementing the programs; and, again, reemphasize funding sexually explicit prevention and education materials.

I also want to underscore the necessity to do research, and research which correlates pre-Colonial sexual mores or norms, or indigenous and traditional beliefs, which go hand in hand with western beliefs. Because, in people of color communities, there is an historical basis for why people are acting out the way they do today based on their historical roots. Oftentimes, the traditional and indigenous beliefs go hand in hand or practiced simultaneously with the western beliefs.

I want to underscore, also, the need for outreach and preventable outreach programs, developed from the perspective of the target populations. Particularly outreach to gay and bisexual men. In San Francisco, we don't have a program that does that on an ongoing and consistent basis. And also for women and people of color.

I am working in AIDS as the California AIDS

Intervention Training Center. It was formerly YES, and the City Consortium to Combat AIDS, which was the flagship of NIDA, in terms of dealing with an outreach program, or a model, targeting the IVDU, intravenous drug population. But there really isn't a program like that targeting outreach to gay and bisexual men, and we really, when you look at the statistics, still gay and bisexual men are -- particularly on the West Coast -- are, you know, 80 or 900 percent of the cases. And, in terms of IDUs and HIV, I think there needs to be more correlation between how government branches dealing with like drug use, NIDA, and dealing with HIV, they need to be more coordinated programs.

Lastly, I think, in terms of lobby efforts, we need to reshift our priorities and funding allocations. I was participating in the Life Lobby Day, as well as AIDS Lobby Day, we had in Sacramento May 6. There is a big funding crisis in California. They are projecting a $13.6 billion dollar deficit. And when we look at our legislatures and they look at us, and we, together, we are wondering where this money is coming from. It really needs to come from our federal government, and we really need to shift, reshift, our allocations and our domestic needs.

Thank you.

DR. OSBORN: Thank you very much.

The next person who has asked to speak is Bartholomew Casimir.

MR. CASIMIR: My name is Bartholomew Casimir. I am a staff member, actually, I am community liaison for the San Francisco Black Coalition on AIDS, and I am the chair of the PWA San Francisco. I am also on the national board of People With AIDS.

What I'd like to introduce to the Commission is a report, a study -- actually it's study that we did. We just finished it in February. How this report came about is, that, a group of us gay black men got together last year and looked at what services were available to us out there. We began to look at agencies that are serving our own colors, which is black gay men. And we looked at the Baby Hunter's Point Foundation, which was the only agency that was receiving money to do education and outreach to men who have sex with men. And, of course, we looked at that wasn't being done. So, we challenged Shirley Gross, who is the executive director of Baby Hunter's Point Foundation to this fact. She appointed, asked us, to do a study or needs assessment. She appointed me chair.

So, I'd like to present this to June. I'll bring it over. But one thing I would like to point out in

the report that we did is -- which I think is a very, very important component of this report -- the sexual behavior of black men is not simply a predictable from stereotype. Contrary to expectations, black men who identify as heterosexuals and bisexuals, but who have sex with men, are more likely to engage in high-risk sex with other men than those who identify as homosexuals. Though the behavior of hetero and bisexual black men, who have sex with men, is more dangerous, they may perceive themselves to be at lower risk than homosexual black men.

A similar misconception is reflected in the belief among Black San Franciscans that gays are clearly at risk for AIDS infection, but they are not sure whether bisexuals are. This is a report done by -- a research done by Polaris, which is headed by Noel Day.

Some black people seem to believe that the person's sexual identity is what creates the risk when, in fact, the risk comes from the person's behavior. Clearly, the lives and health and habits of black gay men are inextricably linked to the entire black community. The success or failure of the black community AIDS agenda rest on its ability to serve all black communities.

What I would like to do is challenge the Commission today to promote the health and welfare of homosexuality, as I promote myself to you that I am proud

to be a black gay man, and I've always been. I am 50-years old, and I don't think I'm ever going to change. I've always had very successful relationships with men and women. My successful relationships have been intimately with men. And this is the way my life has been and I feel I'm very healthy.

Each time I do something like this -- I was just thinking the other day that living with HIV infection has been a very, very drastic change in my life. In 1987, when I went to the march in Washington, and when I came back -- I think before I went, my T-cell counts were somewhere around 400; but, since '87, they have been climbing steadily. My last T-cell count was well in the '90s. So, I think, when I do things like this, I increase my T-cell counts at least by one.

(Laughter and applause.)

Thank you.

DR. OSBORN: Thank you very much.

And the fourth person who has asked to speak is Lei Chou. I'm sorry if I don't pronounce that properly.

MR. CHOU: I just want to make an observation in terms of the event that happened to day. I think this is a room full of group of really cynical people, both presenters and the commissioners, in view of

the situation that we have to deal with.

I just kept looking at the things that kept us talking, instead of just shutting up. That's why I am presenting tomorrow as one of the presenters, but I thought I would do something on Asian today and impose on you for a few more minutes. Because, AIDS and HIV is something that I devoted my life to and I really think that I'm worth more than five minutes.

I will switch into my two-person mode, which I'm very used to doing. I'll be gay today and I'll be Asian tomorrow.

To illustrate -- I'm from New York City -- to illustrate the crisis that we have in New York City, 80 percent of the Asian cases, full-blown AIDS-reported Asian cases, are from men-to-men transmission. And 78 percent of that are people who are first generation immigrants. People who were born in other countries, other than the United States. However, all we have at the Department of Health, one person who does, well, he says, outreach to the Asian Pacific Islander communities. He's Chinese. He name is Kei Fong, which in Cantonese is Fong Kei. Unfortunately, also, means a crazy homosexual. Therefore, every time he goes to a public forum, he feels compelled to mention his girlfriend every chance he gets, and he gets this nervous twitch where he shows off his engagement

ring. He's the only person we have.

I want also to make a comment about -- I didn't want anybody to walk out of this room and think that there are no gay Asians, with all due respect to Valli. I feel the necessity to identify myself as person of color and almost always use that term. But, three speakers today, when you went down the list, you neglected to mention Asian Pacific Islanders. I don't know what. It might just be self-conscious, but whatever that means.

The term "Silence = Death," I think that, to be able to say that, and use that as a slogan, is a privilege, a privilege that I have, a privilege that a lot of immigrant Asian gay men, or men who sleeps with men, don't have. For a lot of us, silence equals survival. Because of the intense family structure that we have, that is completely tied to socioeconomic reasons. If we ever dare to come out as a gay man, he ever even dared to come out as person with AIDS, we will be shut out. We will have no means of making a living. We will have no support system.

Therefore, it's been tremendously difficult to organize the gay Asian community, per se, in the New York City area because, for the most part, it's a very recent immigrant area. We have had so much trouble that, for me, personally, I can -- I have a very radical

political agenda, and I can say that I chose not to sleep with any white people because the intense racism that I must face. But, when I say that, I am alienating a huge population of people who should be -- who I should be a community with. I don't have the luxury to say what I think should be said and should be done.

As a result of that, with Silence = Survival, at the same time, if we don't even have a community, we cannot compete with well-established organizations for the limited funding that we have to deal with, that we have to work with. I just want to like put that point out and for underlining all the other gay men of color have said in terms of privileges, in terms of what you can and cannot do.

Thanks.

DR. OSBORN: Thank you very much.

(Applause.)

DR. OSBORN: My thanks and all the thanks of all the commissioners to the people who have just spoken to us, and a very special thanks to the thoughtful input from the panelists who have been working with us all day. I hope we will be able to take good advantage of the insights you have given to us.

MS. HYDE: I really have something burning in me to say. So, Dr. Osborn, I appreciate your just

letting me have a moment.

I hope that, when the Commission sits down to consider what you've heard today, and as you begin to deliberate how you might craft recommendations from today's testimony, you will not allow yourselves to be limited by the policies that have been, and that you will not be limited by what we might call the politics of possibility on Capitol Hill; but, rather, you will sift through and, in good faith, come up with some truth that you want to speak. And, as Miguel said, it will be then other people's jobs to try to take your recommendations and see them through a political process. But that -- I really implore you to be as persistent and persuasive as you can be. And we will, all together, I think, be able to prevail.

I also want to thank you for your attentiveness today.

DR. OSBORN: I'm going to ask you to make the last comment very quickly, Randy.

MR. KLOSE: Welcome to San Francisco, the heartbeat of gay and lesbian America. I would really like to encourage you -- we've talked a lot about sex all day long -- Oh, my God! -- but I would encourage you, as commissioners, to go down to Castro and 18th Street tonight and just walk around. You will see gay and

lesbian America. Like you will see book stores, you will see restaurants, you will see bars, you will see theatres, you will see barber shops, just go and -- you like talked about us all day, just go and look at us.

So, here are ten copies of the Sentinel, and Castro and 18th is only $2.65 cab ride.

Thank you.

DR. OSBORN: Thank you for your welcome.

We are adjourned until tomorrow morning.

(Whereupon, at 4:50 p.m., the hearing in the above-entitled matter was adjourned, to reconvene at 8:30 a.m., Friday, May 17, 1991.