TRANSCRIPT OF PROCEEDINGS

NATIONAL COMMISSION

ON

ACQUIRED IMMUNE DEFICIENCY SYNDROME

THE FUTURE OF THE HIV EPIDEMIC:

THE POTENTIAL FOR CHANGE

Pages 1 thru 191

Washington, D.C.
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NATIONAL COMMISSION

ON

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THE FUTURE OF THE HIV EPIDEMIC:

THE POTENTIAL FOR CHANGE

Tuesday, January 14, 1992

10:20 a.m.

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PROCEEDINGS

CHAIRPERSON OSBORN: Thank you for your patience and translocation for this meeting. We tend to take a lot of responsibility in this Commission, so we'll take responsibility for the Washington water main break as well and apologize for that.

We want to say a special word of welcome to Earvin Johnson, who is joining us for our first regular Commission meeting. We are really delighted to have his talent added to that of the other Commissioners.

Welcome.

[Applause.]

CHAIRPERSON OSBORN: We're going to try and accomplish during the morning what we had scheduled to accomplish during the morning, which means I am going to have to ask the people whom we have asked to speak to us to do so a little bit more briefly than they were planning. I hope that will be all right.

We'd like to make slight rearrangements on the agenda that many of you will have, postponing general discussion so that we can try to be done with the presentations by 12:30, when there is a fixed obligation that some of

us have to meet. But then we will have general discussion and public comment later in the day after we've had a chance to meet that obligation.

So to the people we've asked to come and talk with us, I'm going to offer apologies for my colleague Dr. Rogers here, because he is a very heavy hand with the microphone if we start going over. But I think that we've got a very experienced group of people talking with us, so David may not have to do that.

Do you have any comments you want to make before we get started?

VICE CHAIRMAN ROGERS: No. I'm always the bad cop, and June is the good cop. So if I begin to look like I'm going to have a seizure, please wind up your remarks fairly speedily.

CHAIRPERSON OSBORN: With that, I'm going to ask Dr. James Curran to start off for us.

Jim, thank you for being here. I know that things have been very strenuous at CDC this week, so we particularly appreciate your taking the time to come and join us as we start looking at the epidemiology of HIV/AIDS with an eye to the future.

Thank you.

DR. CURRAN: Thank you, Dr. Osborn.

VICE CHAIRMAN ROGERS: Jim, let's be sure they turn your mike on.

CHAIRPERSON OSBORN: One of our problems, for those who don't know that we had to shift, is that we're running very short of live microphones, so there will be a little of that kind of annoyance, moving them around a bit. There is only one per area, as I understand it.

DR. CURRAN: Thank you, Dr. Osborn and Dr. Rogers. I'm very pleased to be here today. I would also like to welcome Mr. Johnson to the AIDS Commission and what will be, I am sure, an exciting and fatiguing commitment to dealing with the HIV epidemic in the United States.

I am very happy to be here today to make three basic points. One is that despite the numbers of problems we've had with AIDS and HIV in the United States, we have to continue to remember that the HIV epidemic is a brand new epidemic in the history of the world. It is hard to imagine that just slightly over ten years ago there was no such thing as AIDS. We have experienced an enormous number of health and social problems in the United States, with 206,000 cases

reported to the CDC and over one million people infected with HIV, the AIDS virus.

It is hard for us to imagine that most of the 133,000 deaths that have been reported in the United States occurred among people who were infected before AIDS ever existed in the public mind, before AIDS was ever discovered.

This is a brand new epidemic in the history of the world, and in most of the world, AIDS and HIV is in its infancy. The virus is clearly winning the battle against the world's populations.

The second point is that HIV and AIDS--AIDS, of course, is the end of the spectrum of HIV disease--the life-threatening infections, cancer and death that occur at the end of the spectrum in people with HIV infection.

It is important to recognize that AIDS is the end of the spectrum in society as well and remember that our society changes as the spectrum changes. In the United States, we now have a mature epidemic, and we have found that many of our solutions and our ability to deal with the epidemic is also sick, much as many AIDS patients become. We have found that many of the things that we need to deal with HIV and AIDS simply are not adequate throughout our society.

As time increases in the AIDS epidemic in a population in the United States, just as it does in the individual, it is necessary to think differently about the solutions that are necessary for HIV and AIDS. We have become much, much more concerned about management of the illnesses within our society and the illnesses within populations of people with AIDS than we do with prevention.

Just as an individual with HIV much make a long-term commitment to dealing with his or her own infection, so a society must make a long-term commitment in dealing with HIV and AIDS. There are no simple solutions to what will be a decades-long problem in this country and in the world.

Finally, in terms of thinking long-term, we have to think about youth and we have to think about prevention. There are billions of people in the world who are not infected with HIV and billions of children in the world who will be growing into a society with AIDS, a society that those of us in middle age did not grow up into. And we have the opportunity and the responsibility to let those children cope and learn so that they, too, can avoid becoming infected with HIV.

Now I'd like to show you, very quickly, a countless

number of slides.

[SLIDES.]

This shows the AIDS epidemic in the United States in terms of reported cases. The blue line is the total number of cases; there are now 206,000 reported through the end of 1991 in the United States. The first 100,000 cases of AIDS were reported in 8-1/2 years, the second 100,000 in two years and two months, and in slightly less than two years there will be another 100,000 cases reported.

AIDS is now one of the major causes of death in the United States and one of the very leading causes of death of young men and women in the United States.

Next slide, please.

You can see that the insidious, long-term trends are a smaller proportion of cases in gay men, men who have sex with men, "MSM", and an increasing number of cases in injecting drug users. Injecting drug use and transmission of HIV in injecting drug users is the driving force of the heterosexual epidemic in the United States of HIV, and the driving force of AIDS in women and children, primarily through heterosexual transmission and injection drug use itself. This trend is expected to continue throughout the

Nineties.

Next slide, please.

You can see that in 1990 and also in 1991, among black and Hispanic men and women, injecting drug use was pretty equally a cause of AIDS and AIDS mortality, equal to that of cases in men who have sex with men, or gay men.

Next slide, please.

There is a 5 percent increase in AIDS cases that were reported in 1991 over 1990, but a 22 percent increase in AIDS cases reported through heterosexual contact. This is the group which is growing the fastest in the United States, the group that is the most difficult to prevent in a sense because of the continued perceived lack of vulnerability on the part of the heterosexual population of acquiring HIV infection.

Next slide, please.

Among cases reported in 1991, the majority of women who acquired AIDS--and cases in women are increasing faster than they are in men--the majority of women acquired their AIDS heterosexually through being a sexual partner of an injecting drug user.

Next slide, please.

AIDS grew from not being a known cause of death to being the eighth cause of death among women ages 15 to 44 in the United States in 1987, the fifth leading cause of death by 1991. As a cause of death, AIDS is nine times higher among black women than it is among white women.

Next slide, please.

Among men 25 to 44, AIDS was the fifth leading cause of death in 1987, the second leading cause of death in 1991 after unintentional injuries and automobile accidents, and caused 14 percent of deaths in 1988.

Next slide, please.

Looked at another way, young men in the United States were starting to have it pretty good, having declines in our death rates--until I got older than 44--having declines in our death rates from the 1950's to 1985. AIDS single-handedly changed that and caused mortality to increase beginning in 1986, and now causes about 20 percent of deaths in the entire country in this age group.

Next slide, please.

You can see that for now, more than five years, AIDS has been the leading cause of death in both young men and young women in New York City, a place which is thought to

be dangerous for lots of other reasons, but AIDS is far and away the leading cause of death.

Next slide, please.

As I mentioned before, HIV is a spectrum of disease. In our country now, as in many individuals, many people with HIV infection are moving toward the serious end of the spectrum since they have been infected for half a dozen years or more. It is now estimated that more than 60 percent of the million infected Americans have severe or moderate damage to their immune system as the result of HIV. And the service burden for social services and medical care for people with HIV is now becoming the predominant issue confronting us in the AIDS epidemic.

Next slide, please.

I just want to point out a few things from the surveys of HIV infection that have been done. What this slide basically shows is that throughout sexually-transmitted disease clinics in the country, the light blue bars, there is a great deal of uniformity of HIV infection in gay men, men who have sex with men, with an average rate of 32 percent.

Our next generation of young boys--my son is now almost ready to turn 13, and his colleagues, as they move

into sexual activity--for those who have sex with men--and it has happened in every country, in every generation throughout the world--they will be confronted with a population with a very high prevalence of HIV infection. Throughout the industrialized world for the foreseeable future, HIV infection will be a major cause of death, and probably the major cause of death, among men who have sex with men.

Most young boys who are homosexual have no social support systems. Their friends, if they knew, would hate them; their parents, if they knew, would discourage them. They have no chance. They need education.

Next slide, please.

In drug treatment centers the pattern is quite different, with a range from zero percent to 49 percent; a very high prevalence on the East Coast and in the Southeast, with spotty, low rates on the West Coast and in the Midwest. We still don't really know why for sure HIV infection rates are low in some parts of the country. That is either an opportunity to continue to prevent infection there, or a warning to those other places.

Next slide, please.

This just shows that among heterosexual men and

women attending STD clinics that HIV infection prevalence is highest in those same areas where the prevalence is highest in injecting drug users, showing the relationship between the two.

Next slide, please.

This shows the prevalence in childbearing women from surveys done among infants born to childbearing women throughout the United States. One out of every 625 women giving birth in the United States in 1990 and 1991 will be infected with the AIDS virus. This is as high as nearly one percent here in the Nation's capitol to even higher in some neighborhoods in the Northeast.

Next slide, please.

Job Corps screens 60,000 disadvantaged youth each year between the ages of 16 and 21. Approximately two-thirds of these youth are black and Hispanic, and one-third are white. The average age is slightly less than 18 years of age. One out of 250 of these youth are infected with HIV by the age of 18. Rates are somewhat higher in blacks and Hispanics than they are in whites. They are only, however, 20 percent higher in men than they are in women.

Next slide, please.

By age 21 in the Job Corps, the rates exceed one percent throughout the United States, and are as high in some neighborhoods in New York City as 4 or 5 percent. Rates are higher among 21 year-old women than they are among 21 year-old men. Thus far, only 200,000 have been tested. These are not isolated people. Active drug users are excluded. They represent millions of disadvantaged youth throughout the country.

Next slide, please.

We estimate there are one million people infected in the United States and that somewhere between 40,000 and 80,000 adults and adolescents are continuing to become infected each year.

Next slide, please.

The World Health Organization now estimates that there are about 10 million people infected throughout the world, but that infection rates predominantly in developing countries, in Asia, Central/South America and Africa, will being this total to as many as 40 million by the year 2000.

The virus is clearly way ahead of any possible prevention efforts in the developing world.

Next slide, please.

So how are we doing with prevention? There is an enormous need for a vaccine to save the majority of the world against HIV and AIDS. The next best thing from a prevention point of view would be curative therapy. Therapy to reduce infectiousness would also be very important. In the absence of curative therapy and a vaccine, we are left with the importance of education and counseling and testing.

Next slide, please.

Education efforts have worked best, I believe, in well-educated gay men in the United States. This is an example from one cohort of gay men who had infection rates before the virus was discovered as high as 20 percent per year in San Francisco. That has continued, and it is as low in many cohorts throughout the world as one to two percent in well-educated gay men. Some people say these people don't count because they are very well-educated, they get outstanding medical care and counseling, they have good access to drug treatment, they know the value of safe sex education and counseling--they are not like most Americans. I say we should put everybody into cohort studies who are at high risk.

Next slide, please.

Gonorrhea cases have continued to go down in the

United States, from a high in the 1970's and early 1980's of one million to about 690,000 by 1990. This is somewhat encouraging. Decreases have been somewhat uniform among blacks, Hispanics and whites, most marked among men who have sex with men.

Next slide, please.

More discouraging, however, has been an extraordinarily rapid increase of infectious primarily and secondary syphilis among black men and women in small towns and big cities in the United States. Syphilis cases numbered 50,000 in 1990, the highest since 1949 in the United States.

This is important for three reasons. One is that the increase in syphilis has predominantly and entirely been in heterosexual men and women, with major declines in gay men. The increase in women has led to a big increase in congenital syphilis, fatal to newborns.

Secondly, it is a concern because syphilis is a genital ulcer disease which can facilitate the acquisition and transmission of HIV infection in high-risk populations.

Thirdly, this increase in syphilis has been related to sex for drugs, cocaine use, and has been found mostly in areas of poverty and urban blight, in minority populations

that are the hardest to reach and at the greatest risk for HIV infection. At the very least, it indicates no change in behavior in this very high-risk population.

Next slide, please.

Kids don't take AIDs seriously. They worry about a lot of things--pimples--my son was worried because his teacher took his CD away so he couldn't give it to some girl he met on the bus. That's all he cares about. They fantasize about a lifelong life of sexuality. They think about it all the time. But you can't get through to them, particularly when you are my age and a parent.

Next slide, please.

But one thing they do is they have sex. They have sex, they have sex, they have sex, they have sex. I should not have said that, but they do it; they have sex. The National High School Sex Survey said that 72 percent of high school seniors have had sexual intercourse by the time they graduate from high school. That's what they told the National High School Sex Survey. That's what the students said. Thirty-nine percent have had sex in the last three months, as this slide shows.

Next slide, please.

As the next slide shows, by grade 12, 55 percent indicate they have had sex in the last three months. For those of us who are too old to remember high school, this is a change. People are having sex earlier than they did in the Seventies. It is true. The National Survey for Family Growth found a doubling in premarital sex among 15 to 19 year-old women and 17 to 19 year-old men between 1970 and 1988.

Is there anything good about this? There is one good thing. Next slide, please.

Kids are using condoms more than we used to. They know what a condom is. And as a matter of fact, 45 percent of the high school kids indicated they used a condom with their last sexual experience; 78 percent indicated that they use contraception. This goes along with the National Survey for Family Growth, which indicates also an increase in condom usage. Sure, they shouldn't have sex. They are taking big risks. If they have sex, they ought to use condoms.

Next slide.

What are we going to do about substance abuse? We're not going to stop the heterosexual AIDS epidemic without dealing with substance abuse. John Kaplan, the now

deceased professor of law at Harvard, wrote a book called Heroin: The Hardest Drug. He said that our current solutions to substance abuse problems were like too small a blanket on a cold night; you shift it around to cover up part of it, leaving another part dangerously exposed.

The National Institute of Drug Abuse estimates there are 1.2 million injecting drug users in the United States. The smallest proportion of those if you divided them into three are in drug treatment today. A slightly larger group are in jail or prison today. And the largest group of the three are out on the streets, injecting drugs, today.

How are we going to stop the heterosexual AIDS epidemic unless we stop the injecting drug use epidemic?

Next slide.

This just reminds me of some of my friends who have died, people I have known over the years--this gay men from New York with Kaposi's sarcoma who I met in 1981.

Next slide.

This is a little baby I met in Kenya in 1982.

Next slide.

This is a person I met down in Port au Prince, Haiti in 1982.

Next slide.

This baby, I did not meet, but one of my staff went to see in Romania, who got AIDS in the Romanian epidemic.

Next slide.

This is the ever-present AIDS quilt in the Minnesota Twin Dome. It always serves to remind me of our failures; the people who are no longer Kenyan or Haitian or gay or straight or black or white, but simply quilts. They are what happens when we don't act fast enough.

We have got to retain our commitment. We have got to have a commitment to prevention, and we can't give up. We have to work together.

Thank you.

[Applause.]

CHAIRPERSON OSBORN: That was I think ten years of passion put into a very few minutes, Jim. Thank you so much. We appreciate such an extraordinary overview.

Our next speaker will be Dr. Dixie Snider, who is going to jolt us into the future, I think, with some discussion of a new facet of the epidemic that is coming along, the issue of tuberculosis and HIV.

Welcome, and thank you, too, for your patience with

our logistic problems.

DR. SNIDER: Thank you, Dr. Osborn, Dr. Rogers.

It is a pleasure to speak to the Commission about an increasingly important problem related to the HIV epidemic and that is the increasing incidence of tuberculosis and particularly the problem of multi drug-resistant tuberculosis which has emerged.

Jim said HIV is a new disease. Tuberculosis is both an old and a new disease. As an old disease, it is estimated there are 8 million new cases in the world each year and 3 million deaths from tuberculosis, mostly because people do not have access to therapy, also because of drug resistance. So it is a tremendous problem in the world.

TB causes 7 percent of all deaths in the world and 26 percent of all preventible deaths. It is a major cause of economic non-development, if you will, and a major cause of orphanism in developing countries.

Tuberculosis is caused by a bacterium, Mycobacterium tuberculosis, which is spread primarily through the air by people who have TB in the lung who are coughing. Anybody can become infected with TB, regardless of their socioeconomic status, their race ethnicity or their general health.

However, a person with a healthy immune system is usually able to contain the infection, but they are not able to eliminate that infection without help from anti-tuberculosis drugs. Most people who are infected with the TB germ are asymptomatic, but they usually have a positive TB skin test, and they can develop clinically active disease at any time during their life, particularly if they come under physical or emotional stress, or if they become immunosuppressed as occurs with HIV infection.

There are two major ways to control tuberculosis. The first way is to identify and treat people with clinically active disease. Treatment for tuberculosis requires a minimum of six months. The second control intervention is to identify and preventively treat people who are infected but not yet diseased, but who are at high risk of developing disease. Preventive treatment requires a minimum of six month.s

The United States has had a significant decline in the number of TB cases over the years. We have gone from 84,000 cases in 1953 to 22,000 cases in 1984. However, since 1984 there has been a 16 percent increase in cases, and we estimate in the past six years, based on projections of prior

trends, we have had 28,000 excess cases.

The increases have been seen among both males and females; they have been seen in all age groups except, interestingly, those over 65 years of age. Between 1985 and 1990, there was an alarming 19 percent increase in cases among children less than five years of age and a 44 percent increase in tuberculosis in children five to 14 years of age. But the largest increases have occurred in young adults. Among those 25 to 44 years of age there has been a 44 percent increase in cases. The increase was 11 percent among Asians, 25 percent among whites, 55 percent increase among blacks, and a 77 percent increase among Hispanics.

Much of this increase seems to be due to tuberculosis occurring in persons with HIV infection. CDC sero surveys in 20 metropolitan areas have revealed that up to 46 percent of TB patients have HIV infection. HIV infection is the strongest risk factor for TB that has ever been identified. It impairs the immune system and makes the individual more susceptible to developing tuberculosis if they carry the latent TB infection, but HIV also makes a person at extraordinarily high risk of developing tuberculosis if they even become exposed to the disease.

We don't know exactly how much of the increase is attributable to HIV infection because the health departments do not routinely collect information on the HIV sero status of tuberculosis patients, and until more information is available, they question of how much of the increase in tuberculosis is attributable to HIV cannot be definitively answered.

There are other problems with tuberculosis, however. TB in the foreign-born has shown increases over the last few years, and about 24 percent of our cases currently are occurring in the foreign-born. Other groups at high risk for TB include persons in group or institutional settings, such as correctional facilities, shelters for the homeless, residential care facilities, nursing homes and hospital. This is so for two reasons. First, people at high risk for TB are more likely to be in these institutional settings; and second, these environments are conducive to airborne transmission of TB. There are a large number of people sharing the same air for long periods of time.

The most recent threat to TB control is the outbreaks of multi drug-resistant tuberculosis. These have occurred in a variety of institutional settings, and I think

the seriousness of these outbreaks is difficult to overemphasize.

CDC has investigated or is investigating six outbreaks of multi drug-resistant tuberculosis in several hospital and prison facilities in Florida and New York. At this time nearly 200 people with multi drug-resistant tuberculosis have been reported. Most of these people are HIV-infected. Mortality among these patients with multi drug-resistant tuberculosis has ranged from 72 to 89 percent. The median interval from diagnosis to death has been from four to 16 weeks.

In addition to hospitalized patients and inmates, transmission of multi drug-resistant tuberculosis to health care workers and to prison guards has also been documented, and several of these individuals have died from TB.

How did we get into this dilemma?

First, the problem results from the duration of treatment. Many patients and many of us do not take medication regularly, for the entire treatment that the medication is prescribed. This is especially true for patients who have mental illness, who are homeless or who are suffering from a substance abuse problem, as is unfortunately often the case.

Reports sent to CDC by State and local health departments indicate that about 20 percent of patients started on therapy do not complete it.

Failure to complete therapy means not only that the person may get worse or even die from TB, but it means that they may develop drug-resistant organisms.

One of the primary uses of Federal funds for TB has been to hire outreach workers to provide directly-observed therapy. This helps prevent treatment failure and the development of drug resistance. In fiscal year 1991 CDC awarded $8.3 million to 34 States, Puerto Rico, Guam, and 10 large cities for this purpose, and we estimate that they saved the Nation at least--at least--$24 million.

But there is also the problem of physician failure to adequately diagnose and treat patients with tuberculosis. This is especially true in persons with HIV infection. In fact, tuberculosis in HIV-infected persons is in many ways a new disease. It often appears at anatomic sites outside the lungs, and when it affects the lungs the chest radiograph often doesn't look like traditional tuberculosis. Furthermore, the tuberculin skin test is often falsely negative in persons with HIV infection.

There is also the inability or failure to follow appropriate isolation precautions within hospitals, which has contributed to the transmission of tuberculosis.

A most serious problem has been inadequate support for State and local tuberculosis control programs. Cutbacks in funds and personnel in some States and localities have left health departments without adequate resources to place noncompliant patients on directly-observed therapy. Their resources have been inadequate to bring the outbreaks under control. Many areas don't have enough treatment facilities for their TB cases. Recently, we have also had shortages of anti-tuberculosis drugs and significant increases in drug costs which have further eroded health department efforts.

High-risk groups are being inadequately screened for tuberculosis. CDC has been able to provide some assistance in this regard. In fiscal year 1991 we awarded $3.5 million in HIV prevention funds to 25 State and local health departments to deliver TB prevention services to persons with or at high risk for HIV infection. We have concentrated on correctional facilities and drug treatment centers.

But another factor contributing is our antiquated technology for controlling tuberculosis. For example, our

standard diagnostic methods and the methods for performing drug susceptibility tests requires weeks to months, so it takes a long time to identify a patient with TB and with multi drug-resistant tuberculosis. We need tests that will allow us to rapidly diagnose and identify patients with multi drug-resistant disease.

The failure to continue investing in the development of new drugs for TB has left us now without effective treatment and without effective preventive treatment regimens for the people involved in these multi drug-resistant outbreaks. We need more new powerful drugs to combat this disease.

Despite all the obstacles there are some encouraging signs, including the increasing concern about tuberculosis in the media, the public, the medical profession; the development of a plan and strategies to eliminate tuberculosis by a Department of Health and Human Services Advisory Council. There is increasing support for TB research by the NIH. There is the recent formation of a National Coalition to Eliminate TB. And there have been this year increasing levels of Federal support. In 1992, we will have approximately $15 million to support tuberculosis prevention activities

and $10 million to support tuberculosis/HIV prevention.

In addition, CDC is seeking permission to reallocate other funds to support research and programs directed at the problem of multi drug-resistant tuberculosis, and with this additional support it will be possible to more adequately address the tuberculosis problem.

Thank you very much.

[Applause.]

CHAIRPERSON OSBORN: Thanks for a very helpful and succinct statement of an emerging problem that is important for us to be looking at carefully.

I think, even though we are going to be pressed for time a little bit later, I'd like to see if there are issues of information that any of the Commissioners would like to pursue before we go on.

Don Des Jarlais.

DR. DES JARLAIS: A question for Dr. Snider. In our current status of making governmental decisions, health needs and compassion are often at a lower priority than most of us would like, but I wish you would comment a little more on your talk about the cost-effectiveness of preventing tuberculosis. I have heard infectious diseases specialists

in New York say that it costs up to $100,000 to treat a single case of multi drug-resistant tuberculosis. It would seem that this would be one place where the most prudent financial decisions made by government agencies would put on some sort of crash program for preventing the further spread of HIV-related tuberculosis.

DR. SNIDER: That is an excellent point. The estimate that I received from National Jewish Hospital, which treats a lot of patients with drug-resistant disease, suggested that it cost $180,000 per drug-resistant case. Compare that to a standard situation in which a patient has susceptible organizations--about $11,000--maybe $12,000 or $13,000 if you supervise the therapy.

Preventive therapy for many high-risk groups saves money. Clearly, there is a feeling among many of us that investing in directly-observed therapy would also be cost-saving, given how much it costs to treat a multi drug-resistant case. I wish I could say that someone had really done a detailed analysis of that, but it hasn't been done, and it needs to be done, but I think we all feel as you do that tuberculosis control would be an investment rather than expenditure of money, that it would save us money if we were

to do the things we need to do.

CHAIRPERSON OSBORN: Dr. Rogers.

VICE CHAIRMAN ROGERS: This is for Dr. Curran. Jim, a magnificent presentation. One of the things that impressed me were the striking differences in incidence of HIV in drug users depending on area, zero to 60 or 70 percent.

Are there any studies as yet, or can you get anything other than soft data on whether this does or does not relate to the availability of needles and syringes?

DR. CURRAN: Well, whenever I see Don Des Jarlais in front of me, the world's expert in this topic, I feel like somebody trying to describe a flood to Noah.

VICE CHAIRMAN ROGERS: I have asked Don this question, but I want you to answer it, too.

DR. CURRAN: I think it is still largely unknown. There have been some correlations about needle availability, but I think it is still largely unknown because in part, even when needles are available, they are still shared. But there are differences in behaviors between the West Coast and the East Coast--but maybe Don might want to clarify it to get this right.

DR. DES JARLAIS: It is obviously a very complicated

question because in many places HIV spread among drug injectors before anybody knew about AIDS, regardless of whether syringes were legally available or not.

I would say probably the most convincing data comes from the studies of hepatitis B infections. Hepatitis B is spread through sharing drug injection equipment, the same way that HIV is spread; it is spread much more easily and is therefore a more sensitive indicator. There are now three studies of cities that have either largescale syringe exchange programs and/or bleach distribution programs--Tacoma, Washington; Amsterdam in The Netherlands, and San Francisco--where hepatitis B has been going down as a result of observed behavior change in drug injectors.

Most of that has been through either legal or illegal syringe exchange programs, so that there does seen to be an emerging relationship between doing AIDS education and providing access to sterile injection equipment.

CHAIRPERSON OSBORN: Thank you.

Harlon Dalton, then Eunice, then Larry Kessler. Then I think, perhaps, if you can all be fairly brief, we'll still be within the constraints of time.

MR. DALTON: Dr. Curran, you've taught us all a lot

about sex among young people in your slides, more than we ever knew, I should point out--

DR. CURRAN: I had limited time, too.

MR. DALTON: And as you pointed out, young people have sex, and they have sex, and they have sex. Are you convinced that we as a nation know as much as we need to know about the precise sexual behaviors that young people--and adults, for that matter--engage in, and if not, how do you imagine this Commission might go about helping us increase our database about sexual behavior?

The second question is that you pointed out that most young men who have sex with other men have no support systems--their friends if they knew would hate them, you said, and their parents would discourage them. What can we do about that? What can we do about developing support systems for young men who have sex with other men?

DR. CURRAN: Well, I guess I'll take the latter one first. I tried to get some adolescent medicine specialists in the late 1970's interested in studying emerging homosexual behavior patterns in San Francisco, and they asked how do we find these people. I said, well, they get infected with hepatitis B, they're finding somebody, somebody is finding

them, and they are finding each other. There has got to be a way to find them.

It is the most delicate of situations, trying to identify adolescents who themselves have not identified their own sexual orientation while they are in the family unit. I would say at one level it is not possible to have outreach, but I think what is possible is to have available resources for people and also to have education programs for teenagers and others that present information about risks that may not apply to everyone. I mean, obviously an AIDS education program is available to people whether or not they have early sexual practices, whether or not they have sex with people of the same sex or different sex, and whether or not they use drugs. Presumably, that has to happen before the first sexual experiences, not afterwards.

I've forgotten your first question.

MR. DALTON: It had to do with do we know enough about sexual behavior, and if not, how do we find out?

DR. CURRAN: Of course, we know very little. We don't know enough. We've been reluctant, really, until the AIDS epidemic, to pursue studies of sexuality in our country. The National Survey for Family Growth and a couple surveys

done out of Johns Hopkins were the extent, basically, of what was known in the Seventies on any national basis.

We are really a schizophrenic country when it comes to sex. We have probably as much sex as most countries--we don't know that, but we think we do--and we promote it all the time--on TV, in soap operas, in movies--along with some increasing trends of promoting smoking in movies, which bothers me. We just take it for granted. But we have a lot of trouble dealing with it, coming to grips and learning about it in our own individual households in privacy.

So I think that's schizophrenic of us. I think it is part of our schizophrenic American nature, and it should change.

CHAIRPERSON OSBORN: Eunice?

MS. DIAZ: I have a question for Dr. Curran. Some of the data and information you are presenting today looks pretty bleak, and I am just wondering if in fact the budgets that you are entrusted with at CDC for prevention and education of the people of this nation are commensurate with the kinds of challenges you see ahead for this country in the next five years, Jim.

I am really concerned that we have in the last two

or three years, in at least some sectors, been pitting care against prevention and education, and I just wonder what your idea is in terms of the total dollars that are going to be available. You will remember the recommendation of this Commission called not only for development of a national strategy, but of a prevention strategy for this country, and I'm just wondering in terms of us being able to push for that recommendation, if you think the money is there, will be there, or is just simply not adequate.

DR. CURRAN: HIV and AIDS will continue to be a large problem in the United States throughout the Nineties. It could have been worse if it weren't for the ongoing prevention efforts that are community-based, health department-based, and based among the people who have HIV and AIDS.

A lot of these prevention efforts are working. Some very recent papers show that people who have been counseled and tested are much more likely to know not to transmit the infection than those who have not. School education efforts indicate that kids throughout the later school years know a lot more about AIDS than they used to.

So I am partially optimistic about the efficacy of prevention efforts. As the AIDS epidemic matures, there is

enormous pressure, as there is in the rest of the health care system, to fund the services, to provide the care, to take care of the TB patients in hospitals, to take care of HIV-infected patients, and to provide AZT.

In 1992 for the first time, the Congress decreased CDC's budget even below the President's request. In past years, they have usually knocked it up. So that indicates, I think, this ongoing pressure in bleak economic times.

I think in the long run we have to get our prevention efforts much more integrated into the health care system. In Dr. Snider's example, it has been recommended now for several years that all HIV-infected people be tested immediately for tuberculosis and vice versa, that all TB-infected people receive counseling and testing for HIV. That isn't done. It isn't done for a variety of reasons. A lot of HIV-infected people don't know their status, either don't have access or do not get counseling and testing because it is not integrated into their health care system enough, not paid for through those mechanisms. Their health care systems can't take care of them. And secondly, in the TB clinics there are simply inadequate resources to do the counseling and testing.

I guess part of the solution is Federal. Part of the solution I think is structural in terms of getting all of this stuff integrated and having it done.

CHAIRPERSON OSBORN: I'm going to give Larry Kessler the last opportunity for a question before we move on and just before I do that, with some apologize for tardiness, we are pleased that the American Sign Language interpreter is now with us, so for those who would like to take advantage of those services, she is here, and thank you.

Larry, I'm sorry that the microphone that is in front of you is not working. If people have trouble hearing, we can repeat the question.

MR. KESSLER: Dr. Curran, you slides today once again demonstrate that some education and prevention efforts have worked in the gay community in terms of reducing the growth in terms of HIV infection, and in some cases reducing is significantly. Yet it still seems to me that we have not been able to do in the other communities what we have done in the gay community, and done through community-based groups, and that is talk frankly, directly and explicitly and use many mediums, with multiple messages--messages that include abstinence as well as condom use, safer sex messages and so

on.

How do we get from there to here? How do we begin to understand that what may have worked in the gay community, we're still reluctant for a variety of reasons, or there are barriers in terms of reaching the heterosexual teenage community or the heterosexual adult community? And I think you know what I'm talking about in terms of the barriers that are either imposed by Congress or by a local community, by a school system, in some cases a neighborhood, or in some cases, by parents. That's where we seem to be losing the substantial ground that we need to gain, yielding the ground to the moralists who don't want that frank, explicit, direct talk.

CHAIRPERSON OSBORN: Can you sort of quickly paraphrase what Larry has said as you answer?

DR. CURRAN: Yes. I think Mr. Kessler was saying that the inroads that have been made by community-based organizations and others in preventing HIV in the gay community have not been as successful or as prevalent in other communities, and what can we do about it.

I think there are three things that I would say. One is, first of all, the efforts in the gay community have

been extensive. The gay community has suffered a virtual holocaust. We are talking about one-third of the population of people going to STD clinics being infected with the AIDS virus, and the average gay man seeing virtually one-third to one-half of his friends die. We're talking about a community that has galvanized around that since the Eighties, with an enormous amount of resources to help itself and help each other.

At the fringes of the gay community, young gay men have higher infection rates--teenagers, men in their early 20s--higher infection rates among minority gay men, among gay men who are immigrants to the country, people who don't participate in the general mainstreaming.

The gay community, although it is clearly a sexual orientation minority, is a minority in only that regard. It is still male, white and middle-class, predominantly.

Other groups have two problems. One is they have a lot less AIDS per capita, and they don't identify with it. "It can't happen to me." Basically, "I know all kinds of people who are having sex, and nobody gets AIDS. It can't happen to me." So they don't have the benefit of the galvanization of going to funerals, if you will.

The second problem is they've got a lot of other problems because it is a problem that is accompanied by poverty and urban blight, drug abuse, lack of prenatal care, no health insurance, violence in the inner cities, drugs, and lots of other problems. And they are saying, "Wait a minute--AIDS has got to stand in line."

And the support--Dr. Gayle will give some very good examples of organizations dealing with heterosexual populations that are very effective--I think it works; it's just that it's a lot longer to go, and it is less of a perceived problem. And that's got to change.

VICE CHAIRMAN ROGERS: Jim, Dixie, thank you very much.

Let me make a preface to the next group, which we are delighted to have. As you realize, we are running short, so to my sorrow, I'm going to ask each of you to take ten minutes; that will permit us to have a little interaction with all of you. And I will be sort of keeping book on you.

Mark, we'll let you set the stage. Dr. Mark Smith, welcome.

DR. SMITH: Thank you, Dr. Rogers, Dr. Osborn, members of the Commission. Good morning.

I have given you written testimony; I will dispense with it. I want to make four points for you today on the subject that I have been asked to speak to, which is health care; what the implications of the change in the epidemic have for health care.

But first I have to put in a plug for prevention. Let me say that I am not an expert in prevention. I don't consider myself one. But I do want to speak a little more to why it is we seem to always have such a difficult time doing what it is everyone seems to say we ought to do. I think it has to do with four things.

First, AIDS is not alone in having a problem of the ascendancy of prevention over cure. It is a very deepseated American trait that we are interested in the latest and the greatest set of machines and gizmos and drugs--and it's not just AIDS; it is violence and heart disease and every other disease I can think of. So before we're too quick to try to dissect why it is within AIDS we don't do prevention, it's not just within AIDS. It is within public health and health in general.

The second thing is that whenever you are confronted with a request or Congress is confronted with a

request for money for health care, there are a lot of powerful interests that benefit from that money--doctors, hospitals, pharmaceutical companies, home care companies, nursing homes, and others.

Now, I'm not suggesting that people are doing so venally. I'm suggesting when there is money on the table to do health care, there are a lot of people who have a lot of juice who will benefit from that.

There are not a lot of people with a lot of juice who benefit from money for prevention, and the people who are the recipients of that prevention are unlikely to identify themselves as recipients and be an active and effective lobby.

The third thing is that people living with HIV infection are of course among the most articulate and persuasive advocates for AIDS funding, and they understandably are interested in money for treatment. Now, I know they also advocate for prevention, but it is almost inescapable that the engine of a lot of the advocacy parades, which seven or eight years ago when many of us started dealing with the epidemic was on prevention, has now turned to how quickly can we get drugs approved, what is the price of the drugs, what

do the clinical trials look like. That's where a lot of the fire and passion is.

And the last thing I think is that we in the treatment world, because of the roots in biomedical science, have lots of fancy charts we can show, and we can offer persuasive evidence if the steady, if slow, progress against HIV. We can talk about increased survival with AZT. We can talk about decreased incidence of pneumocystis. It is still, I think, very difficult for people in the prevention world to organize and present persuasive evidence that their agency, their program, their approach really has effectiveness not only in terms of increasing knowledge, but changing behavior.

So having said all those things, I want to put in a plug for prevention before I launch into my plug for care.

[Applause.]

DR. SMITH: Now I want to talk about four things in health care: 1) who will lead care; 2) what will they need; 3) what is the mix of medical and social services that people need, and 4) what is the interaction of HIV care with the broader questions of reform in the health care system.

On the first question, who will need care, many observers have talked about the trends in HIV. Jim Curran

has shown you it is very clear where the epidemic is headed. Please do not substitute where the epidemic is headed from where the epidemic is. If you are talking about who it is that needs help now, it is the poor of people who are infected now, and in many cities that is still predominantly gay men. In many cities, in my opinion, that will always be predominantly gay men.

I make this point not because I think it is not important for us to understand and anticipate the needs of women, of blacks, of minorities, but because I think I may be one of the few people who can get away with saying we should in our striving to do so not forget that the vast pool of people who were infected in the Seventies and Eighties still is largely comprised in many cases of gay men, and we should not construct a system of care that ignores that because we are so mesmerized with the trends of the data and forgets where the data is now.

In addition I think it is important to recognize that lots of groups that make sense from an epidemiologic point of view make no sense from a care point of view. There is no group of heterosexual transmission. That is not a socially useful group of people. There is no group of women

with HIV infection. These transmission categories obscure substantial differences in age, in class, in preferences, in understanding of their condition, in insurance status, so I think it is important for you to understand that the care system we construct will have to be diverse, will have to allow for choice according to individual preferences of people even within these groups that we tend to stereotype. And I am concerned sometimes when I hear people put forward models of care about how people should be taken care of. We don't talk about how people with diabetes should be taken care of. We do talk about clinical guidelines, what is appropriate and correct medical practice, and in that we are far short, particularly the Federal Government is far short in promulgating such guidelines. But I think we have to be careful about prescribing how it is a certain group of people should be cared for.

Second, what kind of care will people need? I think the hallmark is increasingly complex. With the approval of DDI, with the growth in the number of options for antimicrobial therapy and for antineoplastic therapy, I think you will see in the future the growing complexity of clinical care for HIV disease. A year ago, it was possible to fairly

quickly prescribe a simple course of therapy at least for HIV asymptomatic people that every physician, P.A., nurse practitioner could understand whether or not they had much experience.

I do not believe personally that two years from now that will be the case. I think two years from now we'll be talking about combination antiviral therapy plus/minus immunomodulated therapy, one set of prophylaxis for men, perhaps different prophylaxis for women. And the implication of this, I think, is we have to look at how practitioners understand and receive this information.

The Federal Government has made two important efforts with the AIDS Education and Training Center and with increased efforts by the NIAID to provide rapid communication to physicians. But I am concerned that without greater coordination by the government of dissemination of results of clinical trials, results of FDA licensure, results of epidemiologic trends like those in tuberculosis, multi drug resistance, poorer patients--that is, patients who are cared for in community health centers, public hospitals, private practitioners who work in the inner city, that is, those whose physicians are not members of the AIDS clinical elite--will

not have benefit of state-of-the-art understanding of what goes on. I think this is an important and growing problem given the growing complexity of care.

The third issue is the mix of social and medical services. I'm going to be heretical here, and I apologize. I think that there are many physicians who are coming to be uneasy with the mix of funding for medical and social services. I count myself among those clinicians who I think are quite supportive of the need for social support for people with HIV infection. But my experience has been that people with HIV infection may have vastly differing levels of needs of social support. Some will need emergency housing; some clearly will not. Some will need extensive counseling; some will not. All will need a doctor or a nurse practitioner or a P.A. All will need medical care.

Now, you will not hear many people publicly talk about this. I am one of the few who are dumb enough to get up here and say it. But the fact is that in private I think there is growing unease about how it is decisions are made about the funding for medical care versus social services for people with HIV.

The reason I raise this is precisely the point that

was made before. One of the unintended consequences of the effectiveness of lobbying for AIDS has been that AIDS money tends to be regarded as a single pot and therefore, despite the best intentions of the advocates, among whom I count myself, in times like this, advocacy for greater funding for clinical care tends to be to the detriment of prevention. So providers are pitted against prevention people, and social service providers are pitted against medical providers. I think it will be a growing problem for those of you on the Commission and others to try and figure out the correct mix of medical and social service funding given the greater disparities of infection rates among drug users and gay men in different parts of the country. I am concerned that there is growing tension between the medical and social service communities given one, single, nongrowing pot.

Lastly, I think that the key questions of HIV care, how it will be organized and how it will be financed int he next decade, probably lie less within the epidemic and more with the growing movement for reform of the larger health care system. If, as you know, the epidemic is increasingly becoming "Medicaid-ized", as Peter Arno and Jesse Green have called it, and if the rise in Medicaid expenditures at its

current rate is absolutely unsupportable in the long term, which I think any Federal and State legislature will tell you, then something has got to give.

If the growing concern about the numbers of uninsured middle class people and their lack of access to medical care, their lack of ability to pay for drugs, is going to be on the agenda of Federal and State legislatures in the next few years, I think it is inescapable that what happens for AIDS care will be determined more and more not by specific AIDS-specific legislation and programs, but by the larger context which I believe is changing rapidly.

I therefore believe it is incumbent on those of us who are particularly concerned with AIDS care to pay much closer attention to the developing debate about reform of the larger health care system and pay attention to what a given proposal would or would not do for people with HIV infection since I think that will be the largest single influence on how services for the HIV-infected are both organized and financed in the next decade.

Thanks very much.

[Applause.]

VICE CHAIRMAN ROGERS: Thank you, Mark.

Mr. Johnson?

MR. JOHNSON: Mr. Smith, looking at Mr. Curran's slides, we can see that the blacks and Hispanics have the major problem because AIDS and the HIV virus is larger in our communities. When you talk about prevention, how are we going to prevent this--the numbers just seem to be going up instead of going down. Also number two on that, since you talk about the inner city and care, that means that blacks and Hispanics are in trouble because we don't have the doctors or the specialists in the clinics in the inner city who know about AIDS and who can help blacks and Hispanics. That means that we're just going to die off real quickly.

So what is our solution to prevention and care for blacks and Hispanics?

DR. SMITH: Okay. On the first, I wish I had an answer. I prefaced what I said by saying I am not a prevention expert. There are some here. I wanted to start by saying although I am arguing for care, I think we need to pay attention to that, so I'll leave that to people who know better than I what works and what does ont. I just wanted to highlight its importance.

On care, I think I am a little more qualified to

talk, and I think that a major effort has to be placed on training and equipping people who currently care for poor people to be able to take care of HIV. That's why I said I think we need to continue efforts to get community health centers, to get public hospitals, to get doctors who take care of poor people trained and equipped to take care of HIV, and we've got to look at how it is that care is financed.

One of the very large problems with Medicaid is that Medicaid is structurally linked to AFDC, Aid to Families with Dependent Children. But most of the people with HIV infection in our country are not women with children. So it is extraordinarily difficult for a young man--and most of the people, including in black and Hispanic communities, who have the infection are young men--it is difficult to get them on Medicaid to even get their drugs paid for because of the way Medicaid is set up. That's what I meant when I said the increasing proposals for reforming Medicaid, for reforming health insurance, for reforming the whole system, we need to have a very keen eye for not just how would this deal with the increasing complaints of the middle class, which is now finding itself with a problem with health insurance, but how does it deal with the problem of people who have always had a

problem with health insurance and now have a problem with AIDS as well.

MR. JOHNSON: I have one more--I forgot to add this in. You know, denial is so big. As I have been going around, speaking, and trying to learn from this distinguished group who are on this Commission, and asking what are we going to do to reach our people--you tell me you've been in it longer than I have, and I'm sure you can help me out there.

DR. SMITH: A member of this Commission, who shall remain nameless, told me not long ago "Whatever this Commission does, Earvin Johnson has probably done more to bring this issue to young people, particularly young black people, but young people of all races, than anything we've done in the last two years." I think that's true.

[Applause.]

DR. SMITH: So I guess my answer to the question is probably back on you. I know that you've made a start, and I know that you have ambitious plans. I think that you, along with other people who are carrying this message forward--and Jim is right; Jacob has long experience, and others have long experience with people who have been fighting this battle for a long time--whenever people are ready to join the battle,

that's when to start, and I think there are some signs that we're making some headway.

MR. JOHNSON: Thank you.

VICE CHAIRMAN ROGERS: Thank you, Mark.

We're now going to move to Jane Delgado. Jane, we are privileged to have you with us today. Again, I'm going to ask you to keep your remarks to ten minutes, and if we can, we'll let the rest of the group go through, and I think then we'll have time to shoot at all of you in terms of questions.

Thank you for appearing today. I should say Jane is the CEO for the National Coalition of Hispanic Health and Human Services Organizations. Welcome.

DR. DELGADO: Thank you.

Our organization represents 200 organizations around the country and 600 individuals around the country concerned about the health of Hispanics. I have provided you all with a copy of a report which we just did called "The Impact on Hispanics in Selected States". I think it is an important report because the last time we did this report was in 1987. Since then, we have some new information which is the same old information.

On page 6, we know that for Hispanics since 1981, Hispanics were over-represented as people with AIDS. We also know this about the black community. We're talking about since 1981 we knew about blacks and Hispanics being over-represented as people with AIDS. This is very important. This is not new news. And it is important because too often people are saying this is a new phenomenon. It is not a new phenomenon since the very beginning.

The second thing which is particularly important for Hispanics is on page 9, which is a breakout by State showing category of transmission, either being gay/bisexual behavior or i.v. drug use. What you see is great variability by State, great variability by State, so that in States like Texas, California, Colorado, Arizona, Florida, Illinois, you have gay/bisexual behavior being very important, and in other States like New Jersey, Puerto Rico, Massachusetts and New York, i.v. drug use being very important.

The reason I focus on this is because what we have are different occurrences across the country. We started working in AIDS very early, in 1984, and the world mood was very different. I think what you find now is a very different world mood, not just about HIV, but about people from racial

and ethnic groups which are not white. That is an important consideration because what you are going to see now and in the future--because I was asked to talk about what I saw in the future--is a heavy backlash. And I think that backlash against non-white communities is going to be stronger in the future than we have ever seen. And the way we treat people with HIV is going to be one of the major things that we can look at to see whether as a country we have compassion which extends to all of our citizens.

In that case, when I look at this Commission and its makeup, I'm glad to see that this time we have more blacks and Hispanics on it, but of course we are never truly represented in our numbers, as is the case in the kind of disease we are facing. But I am glad that you are all here.

The other thing we need, if we can't have representation, is we do need a commission like this to come out with an agenda that focuses on blacks and an agenda that focuses on Hispanics. Now, you might say let's do a minority agenda. The fact is that the way the epidemic is playing out in different communities has great variability, and we must address it. When we talk about prevention efforts we have to ask who are the people who have the virus now, who will have

it in the future, how can we reach these people, what kind of infrastructures are in those communities. In the black community, the church, historically black colleges, and a whole host of institutions exist. In the Hispanic community, we have to focus with community-based organizations. As you know, recently, what happened with KCT in Los Angeles when they made statements about the Catholic Church and their participation in HIV activities. We have to look at who are going to be the messengers and be very active about that.

The thing to do in this document which would be very good for this Commission to come out with would also be to talk about system failure. Our health care system fails many people. It has particularly failed black and Hispanic people across the board. So if you come across with a solution, you have to look at how are you going to change the relationships between black and Hispanic communities and those institutions serving them. That's going to be touchy because it means changing the status quo, and changing will require a lot of support from many people.

At the same time as we do that, we've got to look at funding. Remember what I said--since 1981, blacks and Hispanics have been disproportionately represented in HIV.

Have we had funding to address those prevention efforts? I recall being in front of a similar commission and many other advisory committees, and they all said, "Oh, yes, we will serve minorities." And by saying "minorities", they clustered us together, disempowered us, gave us a couple of scraps to fight over. This is 1992, and that is unacceptable. And I think this Commission has to be at the forefront of that charge.

We have to talk about building linkages, the whole continuum of care and what it means to our communities. Our communities have problems in not just getting health care, but social services. Something like AIDS just exacerbates that situation. Let's take it as a situation where we can show what we can really do.

What is also pretty sad is if you look at this report we did on pages 17 to 19, we talk about what can be done. Those are the same things we said in 1987. Five years later, everyone is still stuck where we were. We have made progress. People can turn to some programs. But not enough--not enough to answer the kind of suffering we have in our community.

It is difficult for me, as some of you may know, to

talk about HIV. For a long time people thought I always talked about HIV from the data, but my executive vice president who served with my organization for 14 years died last January, and when he had the first Hispanics and HIV workshop in Los Angeles in 1984, we had seven people who attended. The denial in our communities continues, and the pointing to other people continues.

It is a challenge for this Commission to go beyond and really make a statement, a strategy, a document, to really benefit the black and Hispanic communities.

Thank you.

[Applause.]

VICE CHAIRMAN ROGERS: Thank you very much, Dr. Delgado. You've broken the record. That was seven minutes, and a very eloquent seven minutes.

We are now going to turn to Derek Hodel, who is the Executive Director of People With AIDS Health Group.

Derek, thank you for being with us.

MR. HODEL: Good morning.

I want to dedicate my remarks today to my friend Jay Lipner, who died recently of AIDS after a long, courageous fight. Some of you probably knew Jay. In the time I knew

him, he taught me so much about government, about AIDS, and about doing the right thing.

Jay pushed hard for me to work more "inside the Beltway", and he would have been proud to see me here today. I only hope that I can live up to his expectations.

It is with great sadness that I appear before you today, or I should say that great sadness has prevailed over great anger that very nearly prevented my appearance. As I struggled to conceive of the implications for the future of the AIDS epidemic, I was in turn discouraged, demoralized, and bitterly angry.

This Commission, the second of its kind, has conducted more hearings than I care to count, has visited care facilities, advocacy groups, prisons, research centers. You have talked to doctors, scientists, politicians, people with AIDS. And in this time, while someone with AIDS dies every seven minutes, you have spent countless dollars and untold time preparing reports, by all accounts intelligent, forceful, landmark reports, that have been virtually ignored by a callous, mean-spirited White House, led by a President who promulgates public health policies mired in politics.

You already have the answers. You already know

what you need to know. So I ask myself: Why bother?

Last November, on a day one sportscaster declared we would remember as vividly as we did the one that saw the assassination of JFK, the phones in my office began to ring. It was the media, seeking comment, and this gay white boy was forced to ask: Who is Magic Johnson?

Mr. Johnson, you must forgive me because I don't know any basketball stars. I do, however, know hundreds of people with HIV, and among them are countless young black men like yourself, some successful, some not. Although they too are all HIV infected, to the best of my knowledge, the President has never called them.

Mr. Johnson, I watched as you became an AIDS hero and were added to the very short list that includes mostly children, hemophiliacs and people who think they got it from their dentist. It includes Ryan White and Kimberly Bergalis, whom I believe someone recently called a "saint"--the so-called innocent victims of AIDS. It does not include most of the people that I know.

Mr. Johnson, I ask with utmost humility that you take great care in your newfound role. You are now one among many exclusively innocent victims of AIDS, be they gay

people, drug users, or those Ms. Bergalis saw fit to imply had done something wrong.

To serve as our spokesperson, we ask you to embrace us all, gay or straight, men, women and children, and to have the courage to speak with humanity for all those for whom you have been given a voice.

Mr. Johnson, as you changed the lives of Americans everywhere, you immeasurably changed my life. After years of fighting this disease, I saw the Nation suddenly awaken to the reality that is AIDS, the reality that I as a gay man have lived with every day, the reality that has killed over 130,000 Americans just like you and me. And yet I saw that for most people, AIDS became a reality only because you upset the "us versus them" construction that had previously shielded them from fear. And they were busily, desperately trying to put it back in place.

Still the President of our United States blames those with AIDS for refusing to change their behaviors, suggesting that AIDS is a price they must pay.

Magic Johnson, hero, AIDS anomaly, the great power you now wield to persuade, to convince, to inspire is something that I, in spite of dedicating my life to fighting

this fight, will never know. I cried--again--for my brothers who desperately needed that power years ago.

A long preface, perhaps, for the message that I have to deliver. As I considered what issues to bring before the National Commission on AIDS, I struggled. Is it useful for you to hear again of the 37 million Americans who have no health insurance; of the federally encouraged unchecked avarice of the pharmaceutical industry, amongst the most profitable businesses on the planet; of the grievously misguided Federal research apparatus; of teenagers who have no information let alone condoms to help them avoid HIV infection, to whom we blindly suggest "Just Say No"; of prisoners with AIDS left to die; of drug users whom we blithely advise to stop shooting drugs, but to whom we decline to offer drug treatment, who are counseled to use clean needles, denied access to same, and then prosecuted if they should somehow turn up with them on their own?

Must we really hear again of rampant AIDS discrimination in housing, in employment, in public accommodation? Must we, really?

Tragedy permeates the AIDS epidemic as it does this Commission's work. For this noble body, a smattering of

great minds in its midst, is impotent. I demand to know: Does your responsibility extend no further than issuing reports? Can it be that your mandate, your moral imperative, permits you to identify the enemy and then abandon the fight?

You as commissioners bear great responsibility and must confront this truth. Your reports, like AIDS itself, have been ruthlessly ignored by a callous, incalculably mercenary administration for the sake of politics--excuse me--two administrations.

My attitude has hardened of late. I have no time for ignorance ten years later. I have no patience for those who do not wish to know. I blame inaction not on benign neglect, but on calculated, cold-blooded malice. And I equate silence with death.

I blame you for the death sentences implicit in your laissez-faire approach. It is immoral for you to have gathered such information and formulated such recommendations without screaming, bloody murder, until they are heard. We are desperate for leadership, and thus the only message you will have paid to have me deliver today is if this administration could only be convinced, be compelled, to implement the recommendations this Commission has already

made, we will ave made greater progress than in the ten years spent.

Mr. Johnson, already you have given people with HIV great hope. By your will to live, by your will to beat this thing, your taking control of your illness and you positive attitude show great courage. Sadly, they will not be enough to keep you alive.

Mr. Johnson, what ultimately propelled me to Washington today was the opportunity to challenge you. I challenge you to do what this Commission has been unable to do. I challenge you to call President Bush--not to listen, because we already know what he has to say--but to challenge him to provide the leadership necessary to stem the AIDS epidemic before it kills you, as I am sorry to say, it probably will. I challenge you to educate President Bush, to challenge his simplistic, moralistic thinking that blames rather than helps. I challenge you to confront the President to push him to do more to support research into treatments for AIDS, for it is treatment, not compassion, that will keep people like you alive.

Read the Commission's reports. Ask questions of those who have spent the better part of a decade fighting

this fight. We'll take your call. You help us to find a new voice.

My bet is that the President takes your call, too. God knows that he won't take mine, nor will he take the call of any gay organization, and I would wager that he won't take Dr. Osborn's, either. The choice is yours: You can demand that he provide leadership, or we can wait, we can do more fact-finding, establish more task forces, issue more reports and pretend that we care. Send that message, Magic. We are a thousand points of light, and we are being extinguished one by one.

Thank you.

[Applause.]

VICE CHAIRMAN ROGERS: Mr. Hodel, thank you very much. That was very powerful, and I think Mr. Johnson wants to make at least a brief comment.

MR. JOHNSON: First of all, I am one member of this Commission, and I am learning from all of them. I understand your fight, and I will help in every way that I can.

I want to know, because you say you are a gay man and you have been fighting this for a long time, how am I as a black man going to help the black community, Hispanics,

bring this academic that we have--it seems that we have the main problem. How can you help me to help them get out of denial? What is it that I can take back to them to help them understand what's happening, first of all?

MR. HODEL: I'll make two points. First I want to reiterate a point that somebody made earlier today, which is that gay people are everywhere, and many of them are black and Hispanic and of all colors. So I think that your question about how to best convince communities of color actually points up a real problem in the way that we think about AIDS, and that is by looking at it as an "us versus them" sort of problem.

I really believe that AIDS is what it is today because the first years of the epidemic, the Federal Government looked at it as a gay problem and therefore ignored it, without realizing that it was everyone's problem.

I think that the most powerful message that you can send today to the black community, to the Hispanic community, to all communities, is that this is "our" problem and that "us" includes not only blacks and Hispanics, but it includes white people, it includes gay people, straight people, men, women, and children. It is "us". Every battle that we have

lost in AIDS so far, we have lost because it turned into "them"; it turned into someone else's problem.

And I think that you hold such great power because of your respect, because of your stature, because of your magic, that you can make this a problem for "us".

MR. JOHNSON: I am a part of "us", so we're all included. So thank you, and we're going to fight it together.

MR. HODEL: I hope so.

[Applause.]

VICE CHAIRMAN ROGERS: Thank you very much.

We'll move on. All of you are doing splendidly, and we will have a chance, I think, to interact with the Commission.

We are privileged now to have Dr. Jacob Gayle from CDC. Jacob, welcome.

DR. GAYLE: Thank you very much for the opportunity to join my colleagues once again. Before I go any further I just want to mention that as I talk about the issue of communities, communities very much are comprised of cultures. One practice that is very important in many of the cultures that I personally embody is the recognition and the memory of those who have gone before us and those who will continue to

be with us and struggle within an issue such as HIV. For that reason, I want to surrender just a few seconds of my time so that we can just spend a couple of seconds in silence to honor those who are living in this country and worldwide with HIV disease and those of who have been very near and dear and close to us who have already gone before us.

[Pause.]

DR. GAYLE: Thank you.

In a fictitious city in a fictitious State in a fictitious country, hopefully in a fictitious world, there was a situation that arose where the incidence of heart attacks seemed to rise at an unbelievably steadily increasing rate annually. This city called in the best epidemiologists from an organization perhaps even similar to my own, and they studied this as well as they could and found out that in this city, as heart attacks rose, so did the number of telephone poles, and they made a very clear correlation between heart attacks and telephone poles.

Now, two groups decided that there were ways that you could deal with that issue. One said let's base it all on the data we have in front of us and say if we cut down these telephone poles and decrease the number of telephone poles in

this community, surely heart attack rate has to go down--and cut they did--and heart attacks remained.

The other group said there has got to be something that goes on between those heart attacks and those telephone poles, and the more we know about what is in between, the better we can attack this problem.

I tell you that story from my preventive medicine training many years ago just to say that when I talk about the issue of communities, and in particular as I talk about racial and ethnic so-called minority communities in this country, we recognize that there is absolutely no biological, genetic reason why we see what we see in our communities of color.

But somewhere between the heart attack and the telephone pole, there is a lot going on that we need to better understand and be able to address. Hence that's what I want to talk about today is the issue of communities and in particular for the most part, communities of color.

I know that you have already heard about racial and ethnic so-called minority communities because I have spent many hundreds of miles traveling along with you as we have talked and visited with the black and brown and red and

yellow Americans in our country. I know that you already know all of the statistics about how disproportionately this epidemic has hit our communities of color, especially black and Latino communities.

Perhaps we may not all b as familiar with what we see in seroepidemiology in terms of HIV seroprevalence increasing within American Indian populations, or the absolute fear that I hear about when I visit our U.S. citizens within the Pacific, Hawaii, Guam, American Samoa and other smaller Territories, all Americans, just like you and me, who are absolutely afraid of the fact that they reside within the middle of the U.S. epidemic, the Asian epidemic, the Australian and New Zealand epidemics; Americans at sea, histories and cultures at bay.

I think there are a lot of things that, over my seven years of working in HIV prevention, I have seen change and I am happy to see. The denial is not as great as we saw seven years ago, yet denial remains. Some of the ignorance and the inaccurate information that we all shared has in fact been dissipated in some amount.

I can remember when some of us were able to begin laughing about the mosquito issues and realize that, no,

that's not a way of transmission. And yet, when I look at the data that were collected just last year by the Centers for Disease Control that suggest that 38 percent of black Americans who responded to the National Health Survey believed still that HIV infection can occur from mosquitoes and that 20 percent were not sure; that 39 percent of the Hispanics who responded believed that mosquitoes are likely to be able to infect people with HIV, and 18 percent were not sure--these data alone suggest the fact that the time for HIV and AIDS 101 is not over. We have such a long way to go despite what we might believe for the general population.

It is also scary to see that at the same time we see these inaccuracies, what I call "afraids", another major epidemic, acute fear regarding AIDS, as we see "afraids" continue to spread and to paralyze our communities and to cause us to blame one another for situations that occur within our own households, in our own families, and in fact in our own lives, it is very important that we not forget that prevention is not the last resort, but a very important resort, including education toward behavior change, behavior understanding, and making the kinds of choices that we can in fact live with.

I want to mention the fact that many of us are not unidimensional people; we do not just fit within one community be it a geographic or a functional community. But many of us, because of our racial mixture or because of our community affiliations, are multicultural people. A black man who, for instance, might be gay could very well be, whether identified as such or not, part of his racial or ethnic community as well as his community related to sexual orientation, or it may even by the basketball team he plays on or the bowling league he goes to, or the group that she attends as a sorority or what-have-you. We are all parts of many communities, and as we continue to develop our efforts toward prevention it is so important that we make sure we target as specifically and as explicitly as we can the people who are greatest risk, in the cultural context and understanding, as possible.

I think, for instance, of the silent culture of deafness that many of us never even realize exists amongst us, and the misunderstandings and concerns that we have in terms of perhaps even disproportionate rates of HIV infection amongst a silent population that has many behavioral and social and cultural reasons for in fact being at greater risk

for HIV infection than many of us. Add to that a deaf person of color, who is considered hard to reach not only by his racial or ethnic community but also by the non-minority, non-ethnic populations who may in fact be deaf.

That is just one of the many examples of communities beyond that that we think of when we talk of race, ethnicity or sexual orientation.

Hard-to-reach communities in fact are only hard to reach by those of us who are unfamiliar with the customs and the communications of these populations. My guess is that we all can be reached by someone, whether we are sex workers, drug users, men who have sex with men and may not even identify as gay, incarcerated individuals, deaf persons or others for whom American, English-based society is secondary to our original cultures. We are all nevertheless reachable.

The frustrations that we deal with, what I call the "full plate phenomenon", the fact that it is very hard to be concerned about what will happen ten years down the road, when in fact we're not sure of security, support, and a place to live for today or tonight or tomorrow. Somehow or another, we have to recognize the fact that clearly, as my boss once said, the HIV epidemic has uncovered the soft

underbelly of our society. We can't deal with the symptoms of the epidemic alone without recognizing the economic costs that it will entail and paying those costs, dealing with the social costs that we recognize that it has already uncovered and trying to remedy those. When we deal with this as a public health aspect, we must in fact base public health upon the definition that we hear from the World Health Organization that recognizes health as being much more than just the physical aspect of this epidemic and of well-being, but the mental, the social, the emotional well-being.

I want to stop now, because as a frustrated professor who hasn't talked to a class for many years, I could talk forever and then give you a quiz later. If there is any way I can elucidate further, please let me know.

Thank you.

[Applause.]

VICE CHAIRMAN ROGERS: Thank you very much. That was very eloquent.

We are now going to turn to Janice Jireau. Welcome.

MS. JIREAU: I'd like to thank this Commission for the opportunity once again to talk on behalf of poor women, black women, Hispanic women.

As you all know--I guess everybody except Magic--I am HIV-positive. I lost my husband as a result of this virus. I did not shoot needles into my arm. I did not do many of the risky behaviors that we group people into to cause me to get this virus. But I am infected. And because I am infected I am also affected.

As a black woman who has basically been poor all of my life, I have been subject, just like many black and Hispanic people, to a great amount of injustices by not only the system, but others. I think that unless this Commission begins to reconsider restructuring the course of our current initiatives to include addressing the underlying issues in people's lives, then everything that we do and have done is futile.

People are not just doing drugs. There is some real pain going on in people's lives. And this needs to be addressed. I think historically this country has never considered the emotions of real people, of poor people. They have never considered us as people.

We don't need another Medicaid card, we don't need another welfare check. We need a national agenda. And we need this Commission. We need you, Magic. We need all of

the resources that we have to galvanize and make this happen.

I have written a nine-page statement about the issues, and I am getting emotional, and I don't know if you're even going to read it. I hope you do because it really explains some of the issues that poor people are faced with in this country. And I hope you not only read it, but I hope you do something with it.

I'm just so tired of saying the same thing over and over and over. Are you really listening? We don't have a voice, Magic. We don't have anybody to stand up for us and speak about the things in our lives. We need you. I came here today to tell you that. I came here today to tell the Commission don't have another hearing where we're not going to really do some work. Tell our President, as the gentleman said, tell the service providers. I think a lot of them have become--I guess what I'm trying to say is that it's not a people-oriented AIDS initiative anymore; it is a political AIDS initiative, and people have been lost in this change of agenda.

We're suffering. We need your help. Thank you.

[Applause.]

VICE CHAIRMAN ROGERS: Ms. Jireau, we did indeed

hear you, and we will of course read your statement with great care. Thank you very much for being here. We much appreciate it.

We'll now ask Ralph DiClemente from the Center for AIDS Prevention Studies at University of California, San Francisco, to address us, and then we'll go to questions.

DR. DiCLEMENTE: Thank you, Dr. Osborn, Dr. Rogers, members of the Commission. I'd like to also echo my comments that it is a pleasure and a privilege to be here to address you today.

Epidemiologic surveys indicate that adolescents are sexually active. You have heard Dr. Curran mention the most recent. Also, adolescents are starting sex at an earlier age and having more sexual partners.

I think it is time, if we don't do anything else, that we stop and acknowledge that adolescents in this country are a sexual population. If we can get that point across, I think we have half the battle won.

However, risk-taking across adolescents is not uniform. There are a number of subgroups which remain understudied and underserved--for instance, out-of-school populations, incarcerated youth, homeless/runaway adolescents

adolescents of color, predominantly African American and Latino youth and, two new emerging trends--adolescents who use crack cocaine and those who use alcohol prior to having sex.

With respect to the epidemic of AIDS, we always have to be aware of the latency period. While many adolescents may be infected as teenagers, a lot of them will not be diagnosed with AIDS until their 20s or even into their 30s. The threat to adolescents far exceeds the number of cases among adolescents.

With that said, African American and Latino adolescents have a cumulative incidence six times and five times greater than white adolescents in the United States. Among females, this ethnic differential is even more marked. African American female adolescents have a cumulative incidence of AIDS 29 times greater than white females. Latina adolescents have a cumulative incidence 14 times greater than their white peers.

What about seroprevalence? In a recent study in New York City among homeless adolescents in shelters, 5.3 percent testified positive for antibodies to the AIDS virus.

Dr. Curran also pointed out the recent Job Corps

data--one out of every 250 adolescents seropositive. Also in that Job Corps data, you were able to see the marked differential between African America, Latino and white adolescents.

Some of our best seroprevalence data comes from the military, and testing done on new applicants for military service between 1985 and 1989 demonstrates that African American adolescents for military service had a seroprevalence rate five times that of the white applicants and three times greater than Latino applicants.

While seroprevalence is helpful, incidence data may be more helpful in charting the course of the epidemic among youth. And again the best source of incidence data is derived from studies of active duty military personnel. Since 1985, all active duty personnel are required to take an HIV test every two years. What does this data tell us?

Overall it tells us that African American youth again had an incidence rate 3-1/2 times greater than their white peers. And if you examine the incidence rate by the years 1987, 1988 and 1989, what do you see? Well, you see a steady decline in incidence among white soldiers. Unfortunately, among African American soldiers, you see a sharp increase. In 1989, African American adolescent soldiers had

an incidence rate 14 times greater than white adolescents in the military. That is particularly alarming to me because this is a period when our HIV prevention programs were certainly rapidly being disseminated. We see an increase in incidence among black adolescents, not a decrease, over time.

Based on these findings, I think it is imperative that we have to have a better understanding of adolescent risk-taking, primarily sexual risk behavior. For sexually active adolescents, the best form of prevention is to use latex condoms consistently and appropriately during sexual intercourse. However, increasing consistent condom use has been a formidable challenge. Although adolescents' knowledge of the protective value of condoms has increased over the course of the epidemic, there has not been a corresponding increase in condom use. One national survey suggests that frequency of condom use at last intercourse has increased by 50 percent. However, the fact is, as adolescents are initiating sex earlier and in greater numbers and with more partners, that still means that is a large proportion of adolescents who are having unprotected sex.

Secondly, it is also misleading. I think it is important that we realize that recency of condom use should

never be equated with consistency of condom use. For condoms to be an effective strategy, less than consistent use is an unacceptable risk.

What about understanding the factors associated with condom use? It's not easy. Condom use is a complex social and behavioral interaction which is not likely to be understood in simplistic terms. We have engaged in a number of surveys in San Francisco to identify key features of why adolescents use condoms, and two key features have emerged: Adolescents' perceptions of whether their peers are supportive of condom use, and their communication with sex partners about AIDS.

With respect to peer norms, in a high school sample we found those adolescents who believe that their peers support condom use were four times as likely to use them consistently themselves. This is an interesting finding, and we replicated it with a high-risk adolescent population--adolescents who were in detention facilities. We wanted to see if it would be stable across the different populations, and to our surprise, not only was it a stable predictor; it was a better predictor of condom use. Adolescents in jails who believe that their peers condone and support condom use

were seven times as likely to use condoms themselves. Similarly, we find that communication with sex partners is an equal if not better indicator.

Our findings, of course, though tenuous, have implications for the development of prevention programs. Historically, most adolescent prevention programs have been developed without sufficient empirical information about the strategies that would be most effective in motivating adolescents to adopt HIV-preventive behaviors. One reason is that these strategies have been developed without an understanding of the forces that maintain high-risk behavior, and more importantly, what are the forces that maintain and promote health-protecting behavior.

Early programs were predominantly information based, with schools as the primary dissemination vehicle. The assumption, of course, is that if we increase adolescents knowledge about condoms, about the AIDS epidemic, we will change behavior. However, the relationship between knowledge and behavior is often tenuous, oversimplified, and has at times produced contradictory results. In fact, we have done studies where adolescents with higher levels of AIDS knowledge are also the same adolescents who engage in the highest

levels of risk-taking.

The findings, at least on this point, are clear. Knowledge alone is not sufficient to motivate the adoption or maintenance of HIV-preventive behavior among adolescents. More aggressive approaches are necessary.

One potential approach, playing off the data we have identified in San Francisco, is to use peer programs. Peers provide a more credible source of information, and they serve as positive role models. Some of the findings from peer studies with relation to smoking cessation are also relevant here. In addition to using peers to set an atmosphere conducive to behavior change, we have to teach adolescents the appropriate social skills to make those changes happen.

What about delivering these interventions? It will not only require school based deliver, but we need to utilize multiple strategies, which include social marketing approaches to mobilize community leaders, involve community-based organizations, counseling at STD clinics, media approaches. And we have to have the efforts of clinicians who come into contact with these adolescents well before they become sexually active.

This leads me to a couple of recommendations. First, while there is some information about adolescent populations, the data is fragmentary, limited by small sample sizes and geography. Further funding support is necessary for basic behavioral surveys to identify the prevalence of risk-taking among adolescents in general and among high-risk populations in particular.

Especially, funding is needed for understudied and underserved populations, such as African American adolescents, incarcerated and homeless/runaway youth.

Second, to attain this much-needed information, we must attempt to disengage the research enterprise from the political agenda. Politization of HIV research hampers our ability to conduct basic behavioral studies--for example, the recent derailing of a national survey of teens, which would have given us some of this basic information. Moreover, by disentangling the political web that constricts HIV research, we can communicate the HIV prevention message more frankly and use all the tools in our armamentarium to develop social skills training programs that may be more effective in getting adolescents to adopt and maintain health-promoting behaviors.

Third, much more research is needed to develop and evaluate behavior change, risk reduction and interventions for adolescents. We need multi-site trials, using larger samples, in geographically diverse populations to evaluate program effectiveness. As a corollary, we need greater attention to developing culturally sensitive and developmentally appropriate materials and intervention strategies.

Finally, we need a greater linkage between basic behavioral research and those individuals and organizations developing and evaluating HIV prevention programs. Organizations must also establish greater linkage. For instance, a greater exchange of information between research organizations such as ADAMHA and service funding organizations such as the CDC would facilitate a more rapid transfer of research findings that could be used to develop new programs.

Commissioners, the gauntlet is down. HIV poses a direct challenge to the health of adolescents. This is a war, much like Desert Storm, this is a war, and we need to galvanize our resources accordingly. If we cannot accept the challenge and rise to the occasion by marshalling our fiscal and intellectual resources, then our Nation's most valuable resource--its youth--will be a generation in dire jeopardy.

I trust we will vigorously accept and meet this challenge. The future depends on it.

Thank you.

[Applause.]

VICE CHAIRMAN ROGERS: Thank you very much.

I am now going to turn the microphone back to our chair, Dr. Osborn.

CHAIRPERSON OSBORN: We have 10 or 12 minutes for questions and discussion, which of course is not as much as we wanted to have with such a wonderful group of people to talk with, but we will be coming back later in the day and may have some more opportunity for general discussion.

Just before I start taking questions from the Commissioners, let me say that just before 12:30, we will finish that section of the discussion, and there will be a press conference, which we will have right here. If those of you not involved will make room for the press, that was a pre-scheduled thing. After the press conference, we will be breaking for lunch and then reconvening for public comment.

I again apologize for the disarrangement of the earlier announced schedule. I think everybody in Washington is aware of the water main break that caused us to relocate

the entire session, and that is, of course, the reason. But this is the best we've been able to do to try to get everything in today, so we will be reconvening the general session at 2:30 for public comment, followed then by general discussion and Commission work.

Having said that, let me see if there are questions Scott Allen, why don't you start off?

MR. ALLEN: My question is for Janice. I did read your testimony, and I just want to get more of your wisdom. It was beautiful, and thank you once again. I'm sorry you had to be brief, and could not read all of it to us.

You talked about the holistic healing that is so necessary in this epidemic, that we seem to compartmentalize and do not approach this as a whole issue of a human being, and you touched on it very well here. I'd like your opinion on that, whether it is being attained by the folks in your community. You talked also about the politics, getting into the community-based organizations, and as we are trying to keep the doors open and things like that, are we losing the sensitivity to people. You touched on this a little here, and I wanted some more comment from you on that.

MS. JIREAU: In terms of healing the whole person,

you know, I'm coming out of my own experience, and I need to make that clear. I know what that pain feels like. I am 41 years old, and I am just now getting a handle on the impact of all of that devastation in my life.

We need to not just think of treating HIV: we have to treat the underlying issues. HIV is only one of the many symptoms of what has gone wrong with people's lives, and I think until we can do that--Magic, you are addressing prevention to children. Their parents, their family members are already dying of AIDS. They need to stop the cycle of dysfunction. That is having a tremendous impact. People need to be empowered, to know that they are hurting. Black people don't even know they are hurting. They have been living in such deprivation all of their lives that they think it is a way of life.

In order to effectively plan programs that address these needs, you need to hear from the black community; you need to have people like myself involved in the planning of these programs.

Does that help?

MR. ALLEN: Yes, that helps very much.

MS. JIREAU: Okay. The politics of AIDS--and I

have noticed it even in the black service providers--it's not just the gay politics. People are self-serving. They are trying to build careers on the sufferings of other people. And I also believe that many of them have never once gotten out into the community to really feel the people, to really feel their pain, and this has dehumanized the people.

So we have to do some serious talking and some serious working out, and we have to make AIDS a human issue and not a political issue. Just like everything in this world has been affected by politics, so has AIDS. It is not any different from anything else.

MR. ALLEN: Thank you.

CHAIRPERSON OSBORN: Don Goldman, and then Jim Allen.

MR. GOLDMAN: Thank you. I hope you can hear me.

Dr. Smith, earlier on in your discussion, you talked about the conflict between prevention and care, particularly in the area of planning. In our Commission report and in discussions that we have had, I have always thought it pretty clear that in fact providing care is probably one of the best things we can do to facilitate prevention. When we talk about drug abuse, it is the

treatment of drug abuse that is in fact really the ideal, and the concept of things like needle exchange is really secondary; that it would be better to have treatment available on demand for all; that in terms of care for people, you cannot very well counsel people to stop engaging in behaviors that might increase the risk of spread of AIDS and HIV infection and deny them care at the same time. It doesn't do very much good to tell somebody, that sure, we'll test you for AIDS or HIV infection, and after they are tested tell them, sorry, we can't afford to give you AZT, DDI or DDC, but here is a condom. If someone were told that, one would know what that person would do with the condom that they were given; at the same time they were denied care. So I am concerned about your comments and suggestion that there is a bifurcation between the two does not fully recognize the connection between prevention, care and research as well, all of which are really integrally tied together, at least in my view. I was wondering if you might have any comment on that.

DR. SMITH: Yes. I agree with everything you've said about how much sense these things make, but that doesn't change the reality. The political reality is in most jurisdictions, there is one pot. It's like here is the AIDS

pot, here is how much we're going to spend on AIDS. Now, what do you want to do with it? How much is going to go for research, how much is going to go for care, how much is going to go for prevention?

I am not supporting that; I am reporting it. We don't do it for lots of other diseases. No one would suggest that we reduce the surgeons' fees for cutting out someone's lung so that we can pay for ads to encourage people not to smoke. No one makes that kind of connection. But the fact of the matter is that in AIDS, I believe, both federally and at the State level, people are making these trade-offs all the time. So I'm not supporting it; I'm merely commenting that it is so and that it is one of the byproducts of a successful effort to identify funds as AIDS-specific funds; that's a two-edged sword in that just as they can be increased they can also be decreased.

So I am not encouraging that that conflict go on, but I think the reality is that it is going on, and given the current economic situation, I don't see prospects for that conflict lessening much any time in the near future.

CHAIRPERSON OSBORN: Jim?

DR. ALLEN: A comment to supplement what you said,

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Dr. Gayle. I was talking with the director of a Midwestern blood center earlier this week, and he informed me that they have done community surveys because they have been concerned about the inability to attract enough blood donors. Fifty-three percent of the people that they surveyed were either fairly certain or highly certain that they could become HIV infected through donation. I think that is a very sad commentary on how unable we have been to get the correct message out.

A question for Dr. Smith. Mark, as you well know, many of the medical insurance programs in the United States are employer-based, that is, the employer provides the insurance coverage in one form or another. I was astounded to learn a short while ago that the payer in this instance, or the employer and the payer, could agree to restrict coverage and eliminate some diseases from coverage or to put a cap, maybe $5,000, for services.

Can you comment on what that will do both to the availability of services and payment for services, both in the private and the public sectors?

DR. SMITH: Everyone is referring, I think, to the case problem of Texas--Houston, I believe--in which a person

who had health insurance then made a claim, and kind of post factor a decision was made that, oh, we don't want to pay for this, and we're going to cap this at that rate. That's a very disturbing kind of trend, but it frankly is consistent with the direction that health insurance has gone for the last couple decades, which is that increasingly the insurance market has been defined by trying to get better underwriting and excluding risk from the people that you insure.

The end of my written comments tries to make the point that I think this is an instance where many people will be concerned. Whether or not one is HIV infected or whether or not one is at high risk for HIV infection, you've got to be concerned about an insurance system that says once you need it, it is not there. And that is part of what I meant when I said I think that the solution to some of these problems will lie in larger reform of the health care system. One of the very high things on the agenda, I think, is reform of underwriting rules.

So I frankly don't know that this is going to be a widespread phenomenon. I would think that most insurance companies just from the standpoint of business, good will, would not want to do things like that. Nevertheless the fact

that it happened and was ruled permissible has got to be, I think, a very troubling thing not only for people who are concerned about care for people with HIV infection, but for people who are concerned about care for anybody who is sick, because then what does insurance mean, I think is the question.

CHAIRPERSON OSBORN: Janice, and then Mr. Hodel, I know you wanted to comment on this. And then I'm going to take some final questions or comments from Harlon Dalton and Diane Ahrens. And then I think our time constraint will require us to stop this part of our discussion, but I do want to repeat that we will be resuming at 2:30 and continuing with discussion that I hope will be equally rich.

Ms. JIreau?

MS. JIREAU: Point one--the translation of economics, the lack of economics, and the costing situation on poor people is that we are being given the less expensive treatments, not necessarily the most effective treatments, so it is impacting on the quality of our care and the longevity of our lives.

Point two--We're not asking anybody for the right to be healthy, whole and happy. We are demanding it. It is

a God-given right. It's not something that you can give us; you owe it to us; this country owes that to poor people.

CHAIRPERSON OSBORN: Mr. Hodel?

MR. HODEL: I want to just clarify two points about that case in Texas. One is that that case involved an insured company who decided to switch to a self-insured plan. The case was challenged, and the decision was upheld in Federal court just recently. So the next step will be to appeal it to the Supreme Court. But I think it is really important to acknowledge that that decision to exclude that man was upheld by a Federal court in this country as acceptable.

I think it is also no coincidence that in addition to the fact that this man had AIDS, this was a gay man, and it may have been different had it been someone else with AIDS. It may not have--but it may have.

CHAIRPERSON OSBORN: Harlon?

MR. DALTON: I'd like to thank Jane Delgado for coming out from behind the data and for your testimony today.

DR. DELGADO: That was very hard to do.

MR. DALTON: But one of the things that you said that stuck with me was your concern about the backlash, your

concern that there will be a backlash as people become fully aware of the changed face of AIDS in this country. I think the problem is, Janice, that this country has not made a commitment to poor people or to black people or to gay people or to any of the other groups who are disproportionately affected by this epidemic.

It seems to me that the political strategy--and of course, it is a political disease, as is every disease--the political strategy for ten years now has been that you, too, can get AIDS; that's what the organized gay community did early on when they realized, hey, we're being left out high to dry, so they said, well, you can get, too, and it can be spread heterosexually.

Blacks and Latinos, quite sensibly, sort of tucked our heads in for a while, not wanting to get hung up in this mess, until we went to too many funerals, and it became clear that this is our problem as well, and we said, well, it's your problem, too, to the larger society.

Well, increasingly, it's not--or, at least in terms of the numbers, or at least that perception is out there as fully half of people in this country with HIV or with full-blown AIDS are black and brown, and as we discovered that

heterosexuals with AIDS are by and large black people and Latinos. The question is is there going to be the empathy, is there going to be the support, and is screaming going to make a bit of difference here?

You were suggesting that if this Commission simply stood on a mountaintop and screamed out our recommendations, something would happen. I'm not sure. So I guess I wanted to ask Dr. Delgado if she would sort of play out this backlash phenomenon and what can we do about it.

DR. DELGADO: I think part of the backlash phenomenon is really looking at the problem as something not that you can get or I can get, but as something that impacts us all. And since as a society, what we want to have is increased productivity, healthy people working for as long as they can, we want to see how we can change people's perception of illness. Part of it has to be with giving a broader prevention message. Part of it has to do with restructuring the way we provide health care and also the way we provide health messages.

For example, I credit the CDC for a lot of school-based programs. However, if you focus on school-based programs you are going to miss a lot of black and Hispanic

kids; a lot of the young kids who are gay are not going to be part of the discussion in those programs because their issues aren't going to come up. So I think we have to look at the world in a different way, and that challenges us because it is always easier to do things the same old way, specifically, when some of the research we do comes out the same old way, because that's the only way we are used to seeing the world. So part of what I try to do is to make people look at things differently. Look at what is going on with families. When you have a black or an Hispanic family where there is HIV, how do they relate to it? How do they relate to having someone in that family who is black or Hispanic and gay? How is that played out, and how can we get our messages out in a different way?

At the same time, I like to think globally also, and what I see globally are two things. One is that economies around the world are not doing well. And those economies which are doing well are those who join together with other people. I think as a nation we have to start looking around and joining within our own country arms with each other so we can join the greater community and really push forward for more advances throughout. And I think HIV is a good example

of a vehicle we can use for that. It can make us call to the highest pinnacles of what we are as human beings.

Too often what I see is it dragging people through the mud, and that is what worries me.

MR. JOHNSON: The message is that we are all in it together, but the messages have to be different--

DR. DELGADO: That's right.

MR. JOHNSON: --because you are still dealing with different people.

DR. DELGADO: Exactly. And just like when we sell things to people--like sneakers, like tobacco, like other things--we have different messages for different people. We in the health community can learn from all the research that is done in marketing. We don't have to reinvent the wheel. There's a lot of good data out there that we should apply.

MR. JOHNSON: I think that's the key, too, so that our messages for the different people can be understood in their own communities or whatever.

DR. DELGADO: Thank you.

CHAIRPERSON OSBORN: Diane, we'll let you have the last question or comment, and then we'll continue it at a later time.

MS. AHRENS: My question is directed to Ralph. I think this Commission really supports your comments about the need for further research in terms of adolescent behavior. I heard recently that there had been some research in the area of adolescent behavior particularly geared toward youth that hear the message but are not able to act on it, whose behavior does not change. And that research indicated that among that population there was a high degree of sexual and physical abuse in the home.

I am wondering if you are aware of that, if you would want to comment on it, and if in fact that is the case, how can this population be reached, or is this a problem that is so profound, psychologically profound, that messages, however carefully crafted, will never be sufficient?

DR. DiCLEMENTE: Your question addresses an issue on which we have very little information. In fact there are a number of different barriers to reaching adolescents. I think Commissioner Johnson raised one earlier. Denial is a major barrier particularly among adolescents who are engaging in risk-taking behavior.

Surprisingly, a subsegment of the population of those adolescents who have the highest risk behaviors, the

highest you can possibly imagine, are those who think they have the least likelihood of contracting HIV. Does that make any sense?

Secondly, you are talking about sexually or physically abused. In fact, we have just completed a study looking at a slew of risk-taking behaviors, not only HIV-related, but driving while drunk, suicide attempts, et cetera, et cetera. Do you know what? Those adolescents who have been sexually or physically abused are many times more likely to be engaging in all types of risk-taking behaviors, not only sexual risk-taking. They are also more likely to engage in violence toward other adolescents, violence toward their sex partner, as well as attempted homicide.

Obviously, sexual abuse, physical abuse has left some deep, long-lasting scars, and I don't have the answers to solving that issue now, but I know that's another area we really have to start focusing our energies and understanding on, because abuse is much more prevalent than we can see at the moment. It really is the tip of the iceberg.

CHAIRPERSON OSBORN: Earvin?

MR. JOHNSON: Don't you figure that numbers are not--we can't come at them with stats. We have to talk their

language.

DR. DiCLEMENTE: Exactly.

MR. JOHNSON: I think when we come at kids, we come at them too much with our Ph.D.s and whatever else, instead of coming at them at their level, in a way that they can understand it; is that it?

DR. DiCLEMENTE: I think you are absolutely right. I think we spend not enough time listening to kids and knowing what they want to hear and what is the best way to present it to them.

MR. JOHNSON: Exactly.

CHAIRPERSON OSBORN: At this point, I'm going to have to let the clock drive us a little bit. The press have been rather patient with us today anyway, and I think we don't want to press our luck.

Let me suggest that everybody has about 60 seconds to stand up, stretch, and sit down again. That will give those of you who want to a chance to rearrange yourselves. The Commissioners will then stay so the press can go directly into a conference situation.

[Pause.]

PRESS CONFERENCE

CHAIRPERSON OSBORN: Let me thank you for being quick in rearranging yourselves. We want to be as easy to access as possible.

I'm going to ask Tom Brandt to handle things. I think we won't go with opening comments, since you have just heard three hours' worth of opening comments. I'm going to ask Mr. Brandt to orchestrate this, so if you would please direct your questions to him.

QUESTION: This is for Magic. What kind of leader do you think President Bush has been in fighting this epidemic, and what is your message to him?

MR. JOHNSON: Well, I have only been in this situation for a short time, but the Commission has been together I think for two years, and as you can see, the gay community has been in this fight for a long time, as well as other people who have contracted the virus or the disease. So we haven't come up with prevention, care, or anything else for that amount of time. He needs to do a lot. He hasn't done a lot. He said that himself, that he hasn't been involved in it. So he's going to have to allocate some money and get more involved.

QUESTION: Is that your message to him, that you want him to do more?

MR. JOHNSON: Well, I will speak to him directly about that.

QUESTION: My name is Leonard Brie [phonetic], and I am with Capitol Spotlight. We get a lot of comments from people who say that they represent the black community, who they are and what they talk about, but from the grassroots level, there are a lot of black gays and lesbians who are very upset with you, Magic, from the standpoint that you have allowed yourself to be wrapped around predominantly whites who are not reaching out to the black gay community and the black community.

What do you say to them? How do you respond to them?

MR. JOHNSON: Well, first of all, if they want to talk to me about this situation, I can talk to them about it. I am here, and I'm going to help the black gays; I hope to help the white gays, the Hispanics, everybody of all color in this situation; and then those who have not contracted the disease as well.

I am in this two months old now, and you want me to

sit here and represent all these people, and I'm trying to gather all this information myself--okay? I'm learning from the Commission. I think the people who spoke today, especially Derek, were very helpful as far as how the gays and lesbians are feeling, their anger, and so on.

So all you can do is sit back and wait. You can't judge me on two months; nobody can.

MR. BRIE: How can they get in touch with you? How can they do that?

MR. JOHNSON: I am easily available. We'll get into our situation later.

MR. BRIE: Fine.

MR. BRANDT: We'll do follow-up questions later.

QUESTION: Magic, it is clear that you've become the center of this thing; many of the witnesses addressed their comments to you. One woman said can you be the voice on behalf of the poor, and the gentleman challenged you to confront the President. Is this a role that you undertake willingly? Do you think you can live up to their expectations, or is it too much just now?

MR. JOHNSON: Well, it is a role that I feel that I can live up to. It is another challenge in my life, a

different challenge. Before, I was on my own agenda, when I played with the Lakers and so on, in basketball. Now I'm on God's agenda, and that is to help people fight this as much as possible--get the funding, whatever else is needed, to help people who have it, people who don't have it, and on and on and on.

The people to my right and left will help me; they have already been in this battle, this war, for a lot longer period than I have, and I'm going to look to them for their guidance and assistance and carry on.

We're all in this--it's not just Magic Johnson; it is everybody--and until everybody recognizes that, we're not going to win this war, we're not going to win this battle.

So it's not just going to be on me an on my shoulders. I'm not the only shoulder out here. It's got to be everybody. It has got to be this Commission, it has got to be all of you, the media. We've got to ask you for your help because society has to be educated, and you know that you are the only ones who can educate society. That's it. That's the only way we can do it, through you, the media.

So it's not just Magic Johnson's fight; it is everybody's fight.

QUESTION: Mr. Johnson, for you and for anyone else who wants to answer, there is a promotional spot on television now that says if Magic Johnson can get HIV, anyone can. Some people have criticized that, saying it sends perhaps not the right message, because behavior isn't involved. A lot of today was talking about perceptions of how children are going to get the message. I wonder if you could address that.

MR. JOHNSON: Well--and if anybody wants to jump in here, just do that--let me say this. Any message that you send is going to get shot down, you see, I don't care what it is, because somebody is not going to like it. That's just the way it is. If somebody else wants to say something about that, then go ahead, please.

MR. KESSLER: I'm one of those people, I think, who would be among those who would say that message is the 1983 or 1984 message. It is not as strong as it could be for 1992. It is not direct, it is not explicit. We have had plenty of messages that say AIDS is a problem. We need to tell people how to prevent AIDS. And we also need to make sure that it's not an "us and them" syndrome. There are lines in that PSA that sort of say, oh, my God, AIDS is new; it implies that it's a new phenomenon and that many people

are going to be affected. I say, well, 130,000 people have already died, another million are already infected. It's not new. What we need to do is get past the "us and them", as several people have stated today, and point out exactly how you do get AIDS, not telling people how to call a phone number. And in 60 seconds we can give them some information, but in my mind that doesn't go far enough, and it's not a '92 message.

CHAIRPERSON OSBORN: Just one other comment. There have been a number of witnesses today who have brought out again and again the point--and I think Earvin has, too--that we've got a lot of different communities that we're wanting to talk to, and I think one of the things that you learn pretty quickly, trying to community in a country of this size and complexity, is that there are a lot of "right" ways to do things, and what is going to capture the attention of one person will go right past another; what is going to offend somebody is exactly what someone else needs.

I thin if we recognize the intensity of the problem, we'll be well-off to accept any help.

Harlon?

MR. DALTON: I just want to comment briefly. We

shouldn't put all the weight on that one spot. I happen to think it's a good spot. And I think the one with Rick Patino and Larry Johnson is a good spot. No single 30-second spot, no single commercial, no single Commission hearing, no single statement by Commissioner Johnson or anyone else is going to do the trick. You are in here for the long haul, we're in here for the long haul, and I just wish people would lighten up just a bit and not make a judgment based upon one television spot, or two months. And I'm waiting for the person to ask Commissioner Johnson when he is going to take time for himself rather than taking time for all the rest of us.

QUESTION: Magic, could you share with us in a little bit more detail the emotions that were running through your mind as you were listening to some of the very eloquent statements this morning, particularly those that were specifically addressed to you? Could you be a little more specific, in more detail, about the kinds of things that were going through your mind?

MR. JOHNSON: First of all, you can only read and look at television and the different situations so much. But when it becomes a human situation, when you sit here and talk to Janice and other people who are affected, and Derek was

talking about his friend, and you can go on and on--Elizabeth Glazer is a great woman who has touched me, and she is in this fight as well. So all my emotions come out--I mean, I want to sit here and do more; I want to help the poor; I want to help everybody--now. But I've got to get educated to do that, you see. You can't sit here and ask, "Okay, Magic, how are you going to do it?"

What I'm saying is that first let me get educated, let me find out what the gays need, what the blacks and Hispanics, poor people, this people, that people need. You know, I've got to find out what the President hasn't been doing, and so on. Then, when I'm ready, I will take my fight right to whomever, which is the President on down; you, the media, have to help as well--and then I will be ready. But I can't go into a battle and not know what I'm fighting for, who I am fighting, and who the enemies are.

[Applause.]

QUESTION: Mr. Johnson, you are going to get your first shot with the President this afternoon. How much money are you going to ask for? And also, what is your T-cell count now?

MR. JOHNSON: Basically, I don't talk about myself.

My health is good, and I'm doing all I could do before. I'm running four miles a day, and so on.

With the President, I don't think it's a public thing--that's between me and him right now. Afterwards, we can get into that. But I don't ever tell my strategy before I go to the game. That's stupid. That's like I'm going to lose. So I can't have somebody go out and tell the President what I'm going to say before I get there.

But we're going to have a good discussion, and I'm sure we'll talk after our discussion. The Commission has already asked him for money, and basically I'm just going to ride their coat-tails as far as that's concerned. So the report that you have from them already that they have already put together is basically what I'm taking in there.

This is a good Commission. I mean, this is my first day, but last night--these are good people, and they want to help. But yes, the door has been shut, and we've just got to kick it down. That's it. That's all.

QUESTION: I have two sports-related questions. Yesterday you mentioned that you would like to play in the Olympics, and the Olympic officials have said that if you're healthy, they wouldn't mind. Have your doctors okayed that?

And on an educational basis, how do you let your fellow players know that this is not a contact sport, that you represent no threat playing with them?

MR. JOHNSON: Well, first of all, the doctors and I have already talked about the Olympics, and that was okayed a long time ago, since I found out I had the virus. I could play right now in the NBA; it was my decision not to play because I have another person to think about, and that's my wife, and also another one coming, which is my child. So it was like do I do something for myself or do I do something for my family, and that is why I made the decision to retire--for my family.

To the other part about my team-mates, I practice with them now, I play with them now, and other people, I'm doing the same whether I'm shooting with them or playing one-on-one against them. So they know I pose no threat to them. I want them to treat me the same way they treated me before I got this virus, and they have been doing that.

You see, people have to get educated, society has to get educated. I'm not a threat. People who have the virus are not a threat. You can hug, you can kiss, you can do everything to that person you used to do to them. You are

not going to get it by doing that. And that's why the education and the education parts have to go together, and also care and the other things. But we have to educate the public about what the virus is about and what AIDS is about.

QUESTION: You said several times that you still have a lot to learn about AIDS. I'm wondering what you think that says about all the efforts that have gone before now, that in 1992, a sophisticated and worldly man still doesn't know a lot about AIDS. Also, you heard a lot today about the politics. I am wondering now that you are involved in that end of it, were you surprised by the amount of politics?

MR. JOHNSON: When I say I have a lot to learn about AIDS, it's not so much learning about AIDS; it is about the fight, and why hasn't there been money allocated for the whole fight, where is the door shut, and what the different communities need, because we are all one, but we're still separate. Blacks have a different fight than anybody else, because it is drugs and it is the virus, you see; you've got a two-pronged situation. So you can't address them like you address everybody else because their fight is different, but it is the same.

So whether it's whites, blacks, Hispanics, gays,

everybody's fight is the same, but it is different in a sense.

What was your second part?

QUESTION: Were you surprised by the amount of politics?

MR. JOHNSON: No. Politics is in everything. I mean, that's just a way of life. It's going to be here, it's going to be here after we're gone. It's just here. What can you say?

QUESTION: I have a question for the Commissioners.

MR. JOHNSON: Good.

QUESTION: Everybody talks about Magic Johnson being in this fight for so many years, and he's the one who can now possibly deliver this message that needs to be heard. Do you share the frustration of many people that the White House hasn't been listening to your work? Do you see Magic Johnson as your messenger to get your report through as quickly as possible?

MR. JOHNSON: I think some people didn't hear his question.

VICE CHAIRMAN ROGERS: The question was, in having Magic aboard, does the Commission share the sort of frustration we have heard today in terms of the world is not

listening, the White House is not listening, and is Magic our messenger to the greater world.

I would say yes and no. I think all of us have been delighted with the fact that Mr. Johnson is joining us, and I think it was immediately apparent. The two groups we have had a very tough time getting to--teenagers, black Americans--were suddenly vividly aware of the problems of this disease, and I think all of us feel that Mr. Johnson can help us with those.

I do not feel all gloom and doom. Yes, we are frustrated by the silence at the White House level. We were encouraged by our meeting with the President and the HHS staff a couple months ago. But we want a lot more, and I think that is going to be increasingly evident in terms of some of the actions of the Commission.

Others I'm sure will want to speak to this.

QUESTION: Have you had a chance to read the Commission's report?

MR. JOHNSON: Yes, I've been going over it. Dr. Rogers has been like my mentor because he was the first one I actually met and have talked to at length, and I'm getting to know everybody else. And you can read all you want, but I

need--this has been good for me today. This has been great for me, because I can hear it, I can feel it, and now I know which way I have to go. But I need to really sit down, because there are experts in different walks, in different ways, and I need to sit down and talk with them to understand it better--because you an read all the numbers and so on that you want to, but if Dr. Osborn is not there to explain it to you and so on, then it's just numbers in my head, and I'm trying to figure out how they all work together.

MR. BRANDT: Two more quick questions.

QUESTION: You mentioned how to reach the youth, and not going after the statistics, et cetera. What do you think should be done at this point to better reach the youth?

MR. JOHNSON: Well, what has to be done is first you've got to start with the parents; you've got to start with them. People are still living in the Sixties and the Seventies, and you're putting that on the kids, and that's not what's happening in the Nineties. It's just that way. I don't care, everybody can do all they want to, but if you listened to Mr. Curran and the numbers, and Ralph, sex among teens and adolescents is way, way up. We didn't have the same problems that you had when you were growing up--drugs,

none of it. Then, when we came along, pot was the only thing. Now, you look up, and it's everything and their mother you have to worry about--do you know what I'm saying--it's cocaine, heroin, and on and on and on. And then you have this, the virus and AIDS. That wasn't around then.

So we have to come at them with what's going on now. Forget what happened when you grew up because that doesn't matter to them in terms of what's going on now. They've got rap music, and on and on, and you've got to come at them in a way they can understand in terms of the way they can understand that this virus and AIDS is out there. If you've got to come "hip" at them, you've got to come that way, so you've got to learn how to talk "hip". I mean, you've got to be able to reach them at their level, not at your level, and that's our problem. We've been trying to come at them from the adult level, and they are not listening and they do not understand that.

MR. BRANDT: Last question.

QUESTION: Magic, now that you have captured the attention of black teenagers, what exactly are you saying to them that you think they will hear? What message are you carrying that might encourage someone to modify their

behavior?

MR. JOHNSON: Well, first of all, I've been working with kids since I was 12. I mean, I've been working at the boys' club, I have run the boys' club, on up to running camps and speaking, since I've been in the league. So I have had a lot of experience with kids. And first of all, you can't lie to them. You have to come at them and make them believe you are their friend, and you care about them and love them. Once you get that out of the way, they will talk to you honestly and tell you about sex and this and that.

The way I'm going to come at them is just by being honest about what happened to me--I got the virus, and so on. That's the only way I can come at them, is direct--not hard sell them. "You can't do this"--not that way--just, "Hey, look, it's out here."

I talk to groups differently. I talk to every group differently. And the blacks, I have to talk a little harder, a little tougher. You know that sometimes our heads are harder, and that's why we're in a denial situation. I'm talking real to you; it's just that way.

QUESTION: Can you give an example of what you might say?

MR. JOHNSON: Well, you see, every group is different. It's hard to tell this group what I would tell them, you know it's just that way, because you get a feel for the room. I'm a person who deals with reality and feelings and emotion. So when I'm speaking to a group, I want to feel the room. And once I feel it, then I know which way I should come. Sometimes you can't come so hard because they're that not that type of people, so I come from another direction. Sometimes you go this way; sometimes your voice has to go higher. So you just feel the group--and when I felt this group, I knew it was going to be hostile today, and I was ready for it. [Laughter.]

I just want you to understand this, that Magic Johnson cannot do this alone. I am a part of this Commission; I am one person who is going to just try to do it for everybody, but I know I cannot. And I'm not going to sit here and say I am going to be the savior, and this is going to happen, but I'll tell you one thing--I am going to try my hardest to get money, everything we need to fight this. And if I see the door closed too long, then I'll just have to back out of it, because I'm in it for people, I'm in it for everybody, everybody who has been fighting this for years and

everybody who is maybe going to contract this disease and the virus.

So the only thing I can tell you is I am going to give 150 percent, and that's it, because I don't know what's going to happen tomorrow.

[Applause.]

CHAIRPERSON OSBORN: The Commission will adjourn for lunch.

[Whereupon, at 1:10 p.m., the proceedings were recessed, to reconvene at 2:35 p.m. this same day.]

AFTERNOON SESSION

[2:35 p.m.]

CHAIRPERSON OSBORN: I'm going to ask that we start with the public comment period. We are quite short of time today because of the natural and other kinds of disasters.

I'd like to ask the people who are commenting to be extremely brief, with our apologies for asking you to do that, because I think you have things you want very strongly to say. Since we have to ask you to do that, if that's too brief, we certainly are eager for you to submit written comments as well which we will pay good attention to.

So, with that as an up-front apology, and also an apologize for names because I never get them quite right, I'm going to call first on Philip Panell, D.C. Coalition of Black Lesbians and Gay Men. If you could, in two minutes, give us a sense of what you want us to know.

Is he here?

[No response.]

CHAIRPERSON OSBORN: While they are looking for Mr. Panell, let me go to the next person, then, because our time is short.

George Bellinger, Jr., Minority Task Force on AIDS,

from New York City. Thank you, and we appreciate your being with us. If you can be brief, we'd appreciate it.

MR. BELLINGER: Sure. As you said, my name is George Bellinger, Jr., and I am the Director of Education and Public Information of the Minority Task Force on AIDS in New York City.

Coming here today, I thought that this was just going to be another Commission hearing, and I was really pleased about the diversity of the speakers as well as the comments that came up. What I really want to say is to reiterate what Mr. Hodel said, that now that we have the information--and I understand the politics, the way it is set up--I think it is really important that the Commission use whatever power and whatever contact they have as well as the new-found attention that Earvin Johnson brings to the Commission to support and advocate for more public funds around AIDS and HIV, especially for communities of color and people who are traditionally disenfranchised.

There is nothing else we can do. We are always constantly fighting for the same dollars, and we have to compete with cancer and heart disease and smoking and all the other illnesses in these communities. And if we can come

together for one pot of money to do the support, I think that's real important.

My other point for Mr. Johnson is to say that, as a black gay man living in the age of AIDS, I think it is important that we stop separating communities and understand that several communities need all the money that we can possibly get.

Thank you.

CHAIRPERSON OSBORN: Thank you very much. We appreciate your taking the trouble to comment, and we'll certainly try to make sure that Mr. Johnson hears that.

Did we find Philip Panell?

If not, let me turn to Nathan L. Mensk, Midwest AIDS Training and Education Center. Thank you for being with us.

MR. MENSK: Thank you. Good afternoon.

I am the Director of the Midwest AIDS Training and Education Center which is one of the 17 Public Health Service-funded education and training centers around the country and, as you know, our goal is primarily to educate health professionals. We have been focused highly on primary care and some specific disciplines in recent years.

I really came to respond to a request that was made by one of the commissioners for us to take a look at your report, "America Living with AIDS: Transforming Anger, Fear, and Indifference into Action", which I think is a very apt title for today given the conversation we had this morning, and talk a little bit about how the ETCs can help in that particular set of recommendations.

We were very pleased to see Recommendation 16 in particular, which focuses on education and training programs for health providers. Actually, we oftentimes assume that health workers are experts and can provide information and prevention and care, but all too often we forget that they are human beings who have had to adjust to the knowledge explosion in the same way all the rest of us have, and particularly those in areas that are particularly affected or not particularly affected, those two ends of the continuum where there is a particular need for support and education. We were particularly pleased to see the recognition for that. The provider really can't teach or provide adequate care without training and support. And as experts who really can be well-equipped to help teach prevention skills to an array of citizens, this is a particularly important point.

As my testimony, there is a written statement which you will receive, and can be incorporated into your thought in the future, but I wanted to just mention a couple of other recommendations that we looked at.

One has to do with the dissemination of state-of-the-art treatment information. This is something that we are clearly ready and willing to help with and are doing so already. Another one has to do with being helpful in recruitment of under-represented populations in clinical trials. Being that we are very involved with community-based organizations and the provider community, who can sort of act as arms and legs for us to help us do that, I think we can be helpful with those recommendations as well as contributing to behavioral and social sciences research. Particularly since most of us are situated within health science centers, we have linkages both to the academic community and to the provider community.

So altogether I would say that the ETCs are really a tremendously potent resource, but I would also say that we're not being fully utilized and taken advantage of in the face of the epidemic. We started with a lot of vibrancy and a lot of enthusiasm, and we were going to march forward and

have a broad brush that we could help where we could based on local needs. It has been difficult to do that more and more because of funding restraints but also because of policies that have been promulgated by the offices administering the ETCs.

There has been a focus on primary care, family care, and we endorse that and support it, but there has not been a real focus on following the epidemic to rural areas, less-affected areas, where it might be increasing. Particularly as the focus has moved to the epicenters, we have had to provide our training there whether or not we felt there were other resources in those particular areas.

I also would point out that we are moving into a third year of either level funding or, in most cases, severe funding decreases, and at a time when the epidemic continues to expand and workers are continuing to need education, I think that that is really not a satisfactory situation for us to be helpful.

In the interest of time, I will conclude my comments, but I very much appreciate the chance to be with you this afternoon.

CHAIRPERSON OSBORN: Thank you. We very much

appreciate your very constructive thoughts. Thank you for being with us.

DR. KONIGSBERG: June, could I make a comment?

CHAIRPERSON OSBORN: Yes.

DR. KONIGSBERG: I'd just like to reinforce the comments that we just heard about the need to get word out to rural America. Having spent some time in the Midwest, I think it is terribly important that physicians throughout America learn the early manifestations of HIV disease, and also TB. I heard some things this morning from Dixie Snider, that sounded like when I first got into public health, and we need to spread that word as well. But I think he brings home a very important point, as I recall, and we had some discussions about that. Not everything that needs to be done will be done in large cities and in health sciences centers. I think your points are well-taken.

CHAIRPERSON OSBORN: Thank you very much.

Mr. Panell, welcome. We introduced you in absentia earlier. Philip Panell, from the D.C. Coalition of Black Lesbians and Gay Men. Thank you for being with us.

MR. PANELL: Thank you very much, Dr. Osborn and fellow commissioners.

I am also an administration of an HIV/AIDS education and prevention and the liberation of ex-offenders through employment opportunities in the Ward 8 section of Washington, which is considered the poorest section of the city--and I'd just stress that, "poor" in terms of money, but definitely not in terms of spirit and resolve.

I am heartened to see that ten years into the epidemic, we are now starting to see more attention being given to the problems of HIV and AIDS in the black community. However, one thing that I find very disturbing at this point is that one group of African Americans that have been hit the hardest and the longest seems to be somewhat ignored, if not being relegated to the background in terms of this problem in terms of the African American community--and I'm talking about the black gay and lesbian community.

I would in no way be so arrogant as to say that there is anything that is spectacularly unique about our misery, or that our pain and suffering is more than that of any other group of persons. After all, we should not be into the quantification of pain.

However, since the inception of the epidemic, the black gay community in this country in general and in

Washington, D.C. particularly, were among the first hit, the hardest hit. We have on a daily basis cried and tended to our sick and our suffering, and we have buried countless numbers of our friends, our significant others, and our loved ones.

And now that we see that the issue of HIV and AIDS in the black community is something that is now being moved to the front burner in terms of the African American community, the focus is basically on women and children and heterosexuals.

There is nothing wrong with that. Anyone who is sick and dying needs help. But we should not forget those people who are gay, who are black and gay, who suffer and chafe on a daily basis under the twin discriminations of racism and homophobia, and because of that type of discrimination, many times are relegated to the margins of society, are basically shunted into the shadows of life, are basically left to suffer alone and to die in darkness.

We over the years as black gays and lesbians in this society have had to cross the burning sands dealing with this epidemic, first of all having to fight with the white gay community over the very scarce resources that were out

there, and then we had to beg, to plead and to pray that our black brothers and sisters would give us just a little bit of understanding, show some compassion and, hopefully, give us even the most meager gesture of love.

I am very disappointed right now that Commissioner Johnson is not here to hear my comments.

CHAIRPERSON OSBORN: He is on his way in, but we're going to have to ask you also to be brief. We'll make sure, though, that your comments are passed along to him.

MR. PANELL: Okay. I would hope that as he comes into Washington--and I did hear him say that he would be visiting on a monthly basis--that Commissioner Johnson would make a good faith effort to meet with the black gay and lesbian community in Washington, D.C. so that we could enter into a dialogue and so that he can be informed of what our struggle has been and to actually meet and dialogue with those people who have been in the forefront of this struggle since the very beginning.

Thank you for your time and your consideration. I deeply appreciate this opportunity.

CHAIRPERSON OSBORN: Thank you very much for those comments.

Earvin?

MR. JOHNSON: I heard a small part of your comments as I was coming in. Are you the leader of the black gay and lesbian--

MR. PANELL: I am a member of the D.C. Coalition of Black Lesbians and Gay Men, and I am very active in that.

MR. JOHNSON: Here in Washington?

MR. PANELL: Yes, I am, yes.

MR. JOHNSON: I want to meet, but I'm trying to figure out who--another guy said the same thing earlier, so I don't know who I'm supposed to meet with.

MR. PANELL: I would be more than happy to facilitate a community meeting with the black gay and lesbian community--

MR. JOHNSON: Okay, good.

MR. PANELL: --at your earliest community.

MR. JOHNSON: Okay. I just want to make sure that I get to the right people.

MR. PANELL: How would I facilitate that, sir?

CHAIRPERSON OSBORN: Maybe through the Commission.

MR. JOHNSON: Yes, through the Commission would be fine, and then we can go from there--okay?

MR. PANELL: Thank you.

MR. JOHNSON: Thank you.

CHAIRPERSON OSBORN: A number of other people have indicated a wish to speak during the public comment period, and it is my understanding--and I'm sure the disarrangements of the day have made it impossible. I don't know that anybody else who signed upon this list is in the room; am I correct? There are two people who are. Could I ask you to take a couple of minutes each, introduce yourselves, since I'm sorry I don't know who's who, and then in turn come and tell us your thoughts.

MR. VITCARM: Magic Johnson, distinguished panel, I am Dr. Swami Vitcarm. I work in alternative medicine; I am a psychologist and an herbalist. I have been working since 1984 on alternative methods to help people heal themselves of HIV.

My opinion is--and I feel it very strongly--that nearly everyone is looking in the wrong direction to handle this disease. Most people are looking at managing it, not curing it. I have done studies. I have been around the world, and I have looked at different substances that help heal people of this disease. I have known several people who

have gone from positive to negative, and there are some substances and things that help this process and need to be investigated.

For example, there is a homeopathic formula that was reported in a medical journal in which seven people so far have gone from HIV-positive to negative. And with natural, alternative healing processes, the substances used and the processes are inexpensive, they are natural, and they are nontoxic.

When we look at a virus, we are looking at something that attacks the whole body, not just one part of it, so all the therapies I deal with, with Us Helping Us, a natural healing group in town, have to do with strengthening the whole body, which includes some modifications in diet, lifestyle, and using substances that help to reverse this disease.

My feeling is that the millions of dollars that have been spent looking at drugs, which have toxic side effects and cause people eventually to lose a lot of the health they have because of the toxicity, is the wrong way to go. So far in the last eight or nine years that I have worked with HIV, I have seen very little interest in natural

medicine, and I think now is the time to take an interest. Like I said, there are the homeopathic medicines, there are some plant extracts being used in Germany; when I was in India, they were using lichisis [phonetic] to manage AIDS very effectively; there are dietary modifications--and these are inexpensive; these are things that can be done now. I think we definitely need to look at those things because getting healthy, and true health, has to do with looking at the body, the mind, the whole lifestyle, and using the right substances.

Many people feel this is a hard way to go because they have to change something about themselves. But I have known several people, like I said, who have reversed the process. So now is the time to investigate this and put some money and some attention behind it, because otherwise we are trying to "manage" this disease with drugs and other toxic formulas, hospitals--all those things cost millions of dollars. These are inexpensive, and I think because of that most of the drug and pharmaceutical manufacturers aren't looking at it because you can't patent natural substances.

So my comment--I'll finish it up--is to go for true health; go for something that naturally is going to make the

body stronger. After all, viruses don't live in bodies that are weak, and viruses attack the whole system. When Bush collapsed the other day, it was his whole body that hit the floor--it wasn't just his pancreas or his stomach or whatever.

I thank you very much for allowing me to make my comments, and I want to thank you all for holding this conference. Thank you very much.

CHAIRPERSON OSBORN: Thank you for being with us. We appreciate it.

MR. DUBEN: My name is Prem Duben [phonetic]. I also work with Us Helping Us, which is a natural healing HIV/AIDS organization here in Washington, D.C.

My comments are similar to Dr. Vitcarm's. We basically work with people who have come off of AZT, DDI, DDC, or who doctors have already told that they have no hope. When they knock on our door, we have to pick them up totally.

We work with at least three groups here in this city and across the country. There are other organizations like us. The trials that are going on in the country right now for any substances do not include many natural substances that can be used to help avert HIV in the system.

My comments today are to encourage the committee to look into this, to encourage all of the organizations to sponsor research and to use research into natural substances. I know that HIV is being studied in this area by NIH and other organizations, but from all the conferences that we have attended recently--I attended the one for clinical trials in D.C. just the other day--there are very few people who know about natural processes for healing AIDS.

The reason it is so important to us here in this city is because we see people that hospitals don't. We work with organizations and individuals who come and knock on our door, looking for simple, natural processes to stay healthy. And without money to fund these agencies and organizations like ourselves, we are left almost empty-handed.

So I encourage the committee today to have as many healthful assistances to this process to help individuals with HIV.

Thank you very much.

CHAIRPERSON OSBORN: Thank you for being with. I appreciate your comments.

I didn't see other hands. Have I missed anybody else who had originally signed up?

[No response.]

CHAIRPERSON OSBORN: If not, thank you.

There is one other thing that is a privilege and pleasure to do just before we turn to Commission business, and that is that we have some friends from the Child Welfare League who are here and wanted to say a few words, and they have a poster that looks awfully interesting.

MR. LEDERMAN: Thank you, Dr. Osborn.

I am David Lederman, the Executive Director of the Child Welfare League of America. We are an association of 650 agencies that work with 2 million kids each year, kids who are abused and neglected, kids who are in trouble in this country. It is likely that almost every child with AIDS or with problems related to AIDS is going to end up in the child welfare system, or a large percentage will, and they will end up with one of our agencies.

About six years ago we really got on top of this issue because it was a critical issue for our agencies. They did not really know how to deal with it, and we helped to kind of de-mystify this thing and help them with guidelines. We developed the first guidelines, and we have developed standards for how you work with children with HIV in residen-

tial programs and day care centers. And we have developed some videos that are training videos. The first was called "With Loving Arms", and it was a wonderful video of women and families in New York City who are foster parents to children with AIDS. It was just an extremely well-done training video. Since then, we have developed a whole series of videos that are really aimed at helping teach folks in our business to work with kids of all ages.

So we developed this poster, which we want to present to you. It was actually a quilt, and it is based on "With Loving Arms". As you know, there are over 3,000 children with AIDS, and there are tens of thousands who are HIV-infected. I know the Commission has not forgotten that there are children who are part of this mix, and the children and families really suffer a lot and need our help.

Our staff, on their own time, as part of the Names Project--I think you know the Names Project, which is for those who have died--did this wonderful quilt called "For All the Children, with Loving Arms, from the Child Welfare League of America. Each of us is someone's child." This quilt has been turned into this poster which we are presenting to you, and we're going to make these posters and hopefully have them

for sale around the country for a small cost.

I'd like to come up and present that to you and thank you for all of your good work, Dr. Rogers, Dr. Osborn, all of the members of the Commission. Magic, we are happy to see you here in D.C.; we know you'll help us a lot.

So I'd like to give this to you.

[Presentation of poster to Commission.]

CHAIRPERSON OSBORN: Thank you.

Now I would suggest we get a little muscle in here and rearrange the tables for our working session. We'll take a few minutes to do that.

[Pause.]

CHAIRPERSON OSBORN: Jim?

DR. ALLEN: I had one comment just to close out the morning session. Dixie Snider was talking to me as we broke for lunch and mentioned that he had had one other thought he wished he'd been able to express to the group. That was that he has become aware of some physicians, health care providers and facilities that are refusing to take care of patients with multiple drug-resistant tuberculosis. And as he indicated, a large proportion of the people who have multiple drug-resistant TB are also HIV-infected. They are not

refusing care on the basis of HIV infection, but on the basis of the TB.

I think that this is one other evidence that increasingly it can be very difficult for people who are HIV-infected to obtain the type of care and to be able to go to providers across the country to receive their care. I think this is one other trend that he very much wanted us to be aware of and to get across the message that TB may be resistant to drugs, but it doesn't mean that these people have to be shunned by providers and facilities.

CHAIRPERSON OSBORN: Thank you.

Larry?

MR. KESSLER: I guess I would throw this question to Don, since he's our expert in terms of ADA. If this trend develops or we see more evidence of it, perhaps it is time that we think about an amendment to protect people with drug-resistant TB; otherwise we will have a nightmare on our hands.

It seems like a re-run of where we were in 1981-82.

MR. GOLDMAN: Yes, but there is an important difference. It is important to distinguish between irrational fears and rational ones. This is not, honestly, an area of

my expertise, and Harlon, I don't know whether you are familiar with it, but my understanding is, for example, that active tuberculosis is, for example, one disease which nursing homes may discriminate under section 504 in their admission process, and I believe that's the only one. And of course, if you recall the Secretary's original proposals in January with respect to immigration status, active tuberculosis was in fact the only disease on the list of diseases of special significance that would justify barring immigration. And there may be some special considerations regarding tuberculosis that do in fact, medically and rationally, justify special treatment under special circumstances.

So that it is not so clear to simply say that, hey, any discrimination against people with active tuberculosis, particularly with drug-resistant strains, is necessarily irrational under all circumstances.

MR. KESSLER: Except that I would still make the case that education is the key to a lot of this hysteria--but also, it is not a long slide between discriminating on the basis of TB and the perception that one may be at risk for TB. It's the same issue--perception linked to HIV--and therefore you could overnight find huge numbers discriminating

against people with HIV because of the perception that they might have or be exposed to someone with drug-resistant TB. That's what we have to guard against.

CHAIRPERSON OSBORN: Harlon?

MR. DALTON: I have a couple of problems, Larry. One, the Arline case, the Supreme Court case that in fact was not about AIDS but was pregnant about AIDS, was about tuberculosis and turned importantly on the fact that Ms. Arline did not have at that point an active case of TB.

The question is transmission. The question is whether or not tuberculosis, whether it is drug-resistant or otherwise at a particular point in time, can be transmitted through the air. And the difficult thing about the testimony today is that certainly if you are talking about somebody who could transmit TB or any other disease through the air, then I don't think that the ADA or any other statute would protect them from discrimination if discrimination means keep them out of a public setting like a workplace.

So it is a tough issue from the legal point of view. I need to learn more about TB and to learn whether with multi drug-resistant TB, there are stages at which one is vulnerable, but in fact not likely to transmit it. In that

situation, it seems to me you are absolutely right. The fact that it is drug-resistant shouldn't affect the anti-discrimination question; what matters is whether or not you are infectious.

VICE CHAIRMAN ROGERS: June, my own suggestion would be that we leave this and move to our business session.

There is a major conference going on at CDC in the not too distant future; February 10th, Tony Fauci has a major conference on this in Washington, and I think there will be information forthcoming that we can probably use from that. But I wonder about using our time right now to discuss this issues.

MR. KONIGSBERG: I think a little bit of perspective would probably be in order on this. Before AIDS, but back when TB was more prevalent, there was a stigma with TB, and there was the impression throughout society that this was a public health problem and should only be treated by either public health people or specialists. Over the years, I think that changed, and changed for the better.

The other observation I would make is that if I had multi drug-resistant TB, I would want to be treated by somebody who really knew what they were doing. This is not

one of my mainstreaming, soapbox issues; this is when the super specialist is in order.

So the legal issues notwithstanding, we need to be sure that when somebody doesn't treat TB, particularly this type of TB, that this is something that was within their expertise. And then there is the business about physicians have the right to pick and choose their patients--and I know this gets real clouded--but I did want to make the point that you don't want just anybody taking care of this disease.

CHAIRPERSON OSBORN: I think that's helpful, and I'm glad David reminded us that there is some fairly intense scrutiny of this issue coming up that will serve to be very helpful, I think, with all the people who do have special expertise.

We've obviously got a schedule that has to be crunched because we had a full afternoon's worth of Commission business to deal with, and we don't have a full afternoon left, to say the very least.

What I think we should perhaps do is look for the opportunity to schedule at least a one-day Commission meeting which will be solely to accomplish the business of the Commission and won't have the staff having to race around,

trying to get witnesses to rearrange their schedules to conform with the Commissioners' and so on.

I am going to turn the microphone over to Roy, but I would propose that that be perhaps the first order of business, because then we can decide what else we think we can reasonably get done this afternoon, without shortchanging discussion of it.

So, Roy, could I ask you to take over now and maybe talk first about whether to schedule a business-only Commission meeting and if so, when?

DR. WIDDUS: Thank you.

The concern that I raised at the last meeting in regard to a meeting in February was predominantly related to whether it was a hearing or not. I think some commissioners feel it would be useful for a business session in February, and I'd be quite open to that in order to get full input from the Commission on the proposed Work Plan. We are trying to sort out the dates which were originally proposed for the February meeting. If those are still possible for people, then we can perhaps tentatively schedule that.

The dates that were previously proposed to you were for Monday, February 10th and Tuesday, the 11th. We know

that many of the dates proposed were difficult for Diane, particularly Tuesdays, so I would suggest that if Monday, the 10th of February is still a possibility for the majority of commissioners, we schedule that as a date for Commission business. It is not too far away, and we could probably deal today with those things which are urgent items that the staff need guidance on in order to continue to proceed on the Work Plan. The bulk of the Work Plan discussions and discussion of things that come later int he year can happen to a fuller extent on the 10th of February, if that's a suggestion.

There then will be about four items which we need your guidance on this afternoon, including settling upon dates for other meetings throughout the first part of the year.

VICE CHAIRMAN ROGERS: June, I am pausing only because that date, February the 10th, is the day that Tony Fauci is having this big TB meeting, to which I am committed--but I don't think that should influence you. It looks like everybody else is available then, so I'd say go to it. If I can get away from part of that, I will.

DR. WIDDUS: We can try to schedule the location such that it would be convenient for you, too.

CHAIRPERSON OSBORN: Charles?

DR. KONIGSBERG: I would support the notion of a working meeting or business meeting in February. I'm not sure how many more hearings we need, or how much data gathering, but I think it is important that we be in close contact with each other and with staff and know what's going on. This is a very ambitious Work Plan. I haven't had a chance to look at it in a lot of detail. And I think since we've been a working Commission rather than a staff-driven Commission, it is important to meet--I know money is tight, and we've got to be careful about travel money as well, but I think it is important.

CHAIRPERSON OSBORN: Diane?

MS. AHRENS: I just wondered--if we're going to do a Monday meeting, most of us have to come in Sunday night, anyway--if we could do the same kind of arrangement, I think it is very good and give us a chance to talk to each other and maybe get some details out the night before. Start with a dinner Sunday night, go through Monday, and have an agreement that nobody leaves before 5 p.m. Monday--I mean leaves the meeting, not the city.

VICE CHAIRMAN ROGERS: I hear you.

MR. GOLDMAN: Is that one of the expressions that suggests a "So moved"?

MS. AHRENS: Sure. It doesn't have to be Washington, either. It seems to me we ought to have the freedom to schedule us someplace else if that's good for David.

VICE CHAIRMAN ROGERS: I will be in Washington.

MS. AHRENS: Oh, okay.

VICE CHAIRMAN ROGERS: But that shouldn't influence this.

MR. GOLDMAN: It looks like a "go".

CHAIRPERSON OSBORN: It sounds to me like we should try and have a meeting that begins Sunday evening, the 9th of February, with an informal get-together, and works through 5:00 p.m. on Monday, the 10th.

MR. DALTON: Realistically, it seems to me airline schedules will have as much to say about when people come and go. I have a 5:25 flight, and that's my last flight out, so I'm not going to stay over an extra day just to be here until 5:00.

CHAIRPERSON OSBORN: I think 4:30 would perhaps accommodate that. I agree that it should be realistic. But if we can do that, then, we'll shoot for 4:00, but no later

than 4:15, 4:30, so that people can make their flights. Okay, it's sold.

Roy?

DR. WIDDUS: There are two memoranda from me to commissioners that I would refer you to. The one on future meeting dates is the one I would bring to your attention first, so that we can settle that.

As Charlie mentioned, there will be activities throughout the year that engage commissioners as individuals and small groups, but it would probably be wise to try to reserve some dates that, if there were a need for a full Commission meeting in addition to the business meeting we've scheduled, that those dates are available for such a meeting, whether it be Commission business or whether it be a hearing on a particular topic.

The memo entitled "Future Meeting Dates" responds to your request for us to go back and look for dates, avoiding Mondays and particular Tuesdays, that were available as single-day opportunities for such Commission hearings. These proposals are based upon our most recent review of calendars, and I thank you for providing your most recent calendars to us.

Looking at March, the originally-proposed dates were the 2nd and 3rd. Checking people's calendars, there is not an alternative where there is good attendance. By "good attendance," I mean something more than about 50 percent of people being available. So the proposal for March, if we decide we need a date for Commission business or a hearing, is that we have a single day's event on March the 2nd, which is a Monday, with the same sort of arrangement that Diane suggested--an early-morning start and a social event on Sunday evening.

In April, there is a little bit more flexibility, the original 20th and 21st dates being Monday and Tuesday. The alternatives, after we've looked for a single day, would be Thursday, the 23rd or Thursday, the 30th. As far as we could tell from calendars as we had them, each of those dates is equally good that all commissioners could attend. If any of you have had changes to the 23rd and the 30th, that might influence which of those dates we actually took and held in reserve.

MS. DIAZ: Excuse me. I think I'm missing something. I wasn't present at the remaining part of the business meeting last time. Did we agree on single-day meetings? I'm

out-of-touch with why--

DR. WIDDUS: To bring you up to the position of everybody, the dates that were looked at and presented to the last Commission meeting, we had searched for pairs of dates--in other words, dates on which commissioners would be available for two successive days. Since most of those fell on Mondays and Tuesdays, and that penalized particular Commission members who have longstanding unbreakable commitments for Tuesdays and Mondays, the Commission asked us to go back and look for single dates that we might hold a hearing or a meeting on, rather than the two-day, two consecutive days.

MS. DIAZ: For the rest of our work? I don't remember that discussion ever.

DR. WIDDUS: The request was basically to try and identify opportunities that were not necessarily requiring people to be here for two consecutive days.

MR. DALTON: I recall that for this meeting; I don't recall that that was a general policy for the rest of the Commission's term.

CHAIRPERSON OSBORN: I think it began to be a more general discussion because the only two-day intervals were

constantly picking up on Monday-Tuesday, and all of the dates that were picked out that were even vaguely reasonable were Monday-Tuesday combinations. So I think what is being proposed here is an alternative. You should feel free to say, no, there have got to be some two-day meetings, but there should be a reason for it, not a perseveration. We do run into problems with other people's calendars when we do it that way because we already know, before people started committing to other things, that there are not nearly enough people available for two-day sequences, particularly in this part of the year. I think a little later on we could perhaps have a little more flexibility, but when you get into April in particular--

MR. DALTON: But I thought Eunice's question was whether we had reached a decision that we would have single-day meetings, and I don't believe we did.

CHAIRPERSON OSBORN: No. We reached the decision that we couldn't have two-day meetings very easily, which is quite different. No, we didn't make that decision, but we certainly did run into problems the minute we tried to extend it beyond that. I think we can return to that when we have some topics that seem to press that, but I don't know quite

how to go about it since we already had impossible calendar combinations before we had another time lag.

Diane?

MS. AHRENS: Madam Chair, as the person who I guess is one of the big problems here in terms of Tuesday, I feel strongly the need for two-day meetings, and even if they affect me and I can only be there one day, I am willing to do that because I think the Commission business demands two-day meetings. So I just want to sort of set the record straight on that one.

In the memo on future meeting dates, it talks about original meeting dates being these days. The only original meeting dates that I have written on my calendar were the ones that we got a memo on from Jeff, and they are very different from the dates here, and I don't know when these dates were decided on, but they were never sent out to us. They were never distributed to us, unless I missed my mailing.

So I'm not sure what we're talking about by "original" meeting dates. But regardless, as the person for whom Tuesdays are always a problem, I would defer to two-day meetings, regardless of whether they are on Tuesdays or not.

CHAIRPERSON OSBORN: One of the issues you raise,

the change and unrecognizability of the dates here, was discussed at the last meeting, and I am sorry if you weren't there. It turned out that the first set of dates that we all put down so nicely, there had been a misreading of calendars backwards on a couple of people, so "x" meant "I can't be there" instead of "I can be there," or something like that-- so they got kind of systematically invalidated, and the staff had to go back and try again. That was done at the last Commission meeting, and what we've got pencilled in, and I'm sorry you don't, is those. But one of the reasons you didn't get a memo about was because then we began to run into this two-day question. So I think that it all got deferred until this discussion.

I should point out that July and August both have two-day meetings proposed now, and I would suggest, to simplify this a little bit, that we look at the desirability of, for instance, sticking with the April dates that came out of that first revision when we got the calendar marking straight, which in my book at least were the 20th and 21st. Those were, at that time, at least, good dates for everybody. And then, if you like, we could try looking at two days in May or June as another effort, trying hard to avoid Tuesdays,

but I appreciate your flexibility there.

MS. AHRENS: And can we do a two-day session in March, or are we dismissing that, March 2nd and 3rd?

CHAIRPERSON OSBORN: I think at the moment, except for you--and Harlon, you had a problem on the 3rd when last heard from--everybody else was okay. And Earvin, I don't know as we have your schedules on here; that's a problem. Right now, March 2nd and 3rd is what we're looking at.

MR. JOHNSON: All the dates that you're talking about now, March, April--and what other month?

CHAIRPERSON OSBORN: We're talking about a February date.

MR. JOHNSON: February is going to be tough for me because it falls on All-Star weekend, and I was just telling Dr. Rogers that Tuesday would have been great, but when you moved it back to Monday, then I had a problem. But all the other dates, I can just pencil those in.

CHAIRPERSON OSBORN: Okay.

VICE CHAIRMAN ROGERS: Roy, I was sending you a note because I realized I have a problem, too. Sunday night is out, and Monday, February 10th, I have another meeting. So I would suggest if you want Earvin and me, it probably

should be Tuesday.

CHAIRPERSON OSBORN: We may have to go for a different date. Let's look at the different sets of dates in February.

VICE CHAIRMAN ROGERS: My suggestion would be put your dates forward, and you are going to miss one or the other of us. I doubt that it's worth negotiating to try and find dates that all of us can be there. You're just not going to do it. You have worked very carefully on that, so why don't you just give us the list of the dates you want us here, and we'll all try and make it?

MR. GOLDMAN: Could I make a general suggestion, which is that rather than sitting here now necessarily--and I'm thinking now, looking at this calendar in terms of particularly focusing on April, May and June--for example, we decide to do something by way of a working group or some other kind of meeting, maybe it would be a good idea to attempt, at least for the short term, to hold the dates that are set forth here as the optional dates aside in any event, and even if they aren't utilized for full Commission meetings they might be used for some kind of subgroup meetings or some other kind of activity that might not necessarily involve

everyone. So at least we would have a few optional dates for that kind of purpose in April, May and June, even though they are only one-day shots.

Does that make sense to everybody?

CHAIRPERSON OSBORN: I think I'm getting a little lost, because we're bouncing back and forth on the calendar. Let's go back to February for just a minute.

I think we've now agreed, or I saw some nodding, anyway, that we shouldn't try and press the 10th, since we've got both Earvin and David otherwise deployed. Then somebody brought up the 11th. I have committed to talking to the Academic Health Centers Task Force from 8:30 to 11:00 that morning, which is a longstanding commitment which is probably important to the purposes of the Commission as well. So I won't be able to be here, and that is probably a problem on the Tuesday. However, that happens to be practically the only day in February when I have difficulties after the first week. So it is conceivable that we can find another way--I don't know how to efficiently find it.

DR. WIDDUS: Regrettably, because the Commission had previously decided not to hold a meeting in February, we didn't do an analysis of availability individual-by-individual

for February. We did it for every other month.

MS. DIAZ: Could we just hand that to you before the meeting is over?

DR. WIDDUS: It would certainly be good if we could get the information from you now, most up-to-date. If you could put on a piece of paper your name and the dates on which you are available, we can do an analysis perhaps by the end of the meeting.

CHAIRPERSON OSBORN: Now, we had talked about March 2nd, and we are talking about extending that to the 2nd and 3rd as dates to be held; is that right? No problems with that. Okay.

April, May and June, the suggestion was that we could hold the original dates--that would be April 20th and 21st--and possibly have smaller group functions then, or some such thing. And a similar suggestion was made for the 18th and 19th of May.

Okay. April 20th and 21st were the dates that were being held. It had been identified that the 23rd, which is a Thursday, or the 30th, which is a Thursday, was a possible one-day set.

What's your pleasure?

VICE CHAIRMAN ROGERS: June, why don't you serve as the czar, and just give us the dates you want us to put down--I mean the day in March, the day in April, the day in May, and so on.

CHAIRPERSON OSBORN: Okay. The 2nd and 3rd of March.

MR. GOLDMAN: Is that starting on the evening of the 1st?

CHAIRPERSON OSBORN: Yes. Then, hold the 20th and 21st of April. That gives us the option of either having a one-day meeting on the 20th, or a two-day function in which some people have to leave, or a two-day smaller group function which people can make.

In May, the original dates were the 18th and 19th. I think we should probably hold those. We don't have a good option that isn't a one-day option. So if we only needed one day, we could just make it the 18th again. Okay.

In June, the original dates were the 15th and 16th. Now, let me make a suggestion here. All commissioners at the moment have indicated they can attend a meeting on June 18th, which is a Thursday, a one-day meeting. We will have held April and May, and we have two-day meetings in July and

August. Should we just try to go for Thursday, the 18th of June, as a one-day meeting and work around that with small groups if we need to? Is that all right, just to break the pattern a little bit?

VICE CHAIRMAN ROGERS: A suggestion. Why don't you just ask us to hold these dates, and if you want to scratch any of them, nobody ever objects to that. Why not hold the 15th, 16th and 18th, and then you let us know which one you want.

CHAIRPERSON OSBORN: Okay, good.

And then July at the moment is clear for Wednesday, the 15th and Thursday, the 16th. The Amsterdam conference is the following week, and I am leaving on the 18th, so that would be about the only time for me.

Then, August the 20th, Thursday, and the 21st, Friday--somewhere other than Washington.

MR. GOLDMAN: June, what did you think of my suggestion that with respect to April 23rd and 30th, and May 21st, that we also attempt to hold onto those dates as free as possible so they can be used for scheduling other kinds of events, or subgroups, or whatever the case may be that we might wish to participate in; and while we have them open,

try to keep them open as a fallback? That was April 23rd, April 30th, and May 21st.

CHAIRPERSON OSBORN: Okay. And now we want everybody to write down what days in February are possible--not the difficult ones, but the possible ones. I think we've already decided that February the 10th and 11th present serious problems, so we are looking for something else. We've got everything else settled except February.

[Pause.]

CHAIRPERSON OSBORN: While that is all being collated, Earvin, would you be willing to tell us a little bit about your afternoon's meeting with the President?

MR. JOHNSON: Yes. Basically, we just started off talking, and he suggested to me in the beginning when we started talking that once I learned which way it is that I think is the direction that he should go, and what is the most important issue and the stand that he should make and take at this particular time, once I learn that, that I should come back in a month or so and tell him--or, I should say, advise him.

I told him that was fine, but that I think right now the American public is waiting for him to just say that

he is aware of this epidemic, and that he needs to come out and say he understands it is a problem out here and that he is concerned, and he cares, and whatever he can do, he will do, and come out and say that he supports the Commission and us.

Basically, that's what happened. I told him that I will be back in a month, because I think I can gather as much as we want to say, but I also want to take yourself and Dr. Rogers in with me when I meet with him in a month, because I've only been here a short time, you've been here longer, and you can really speak to what it is that he really needs to address right now, and then I can take another route--so you can be the good cops, and then I'll be "bad," and then we'll hit him from both sides.

That's basically about it. I did give him a letter, which all of you already know about, which you have written in your Commission report; basically, it was that, the numbers, the money, the allocation--the report that you put together, I just in turn gave him and put in some of my own words in terms of how he can get involved. But we needed the numbers, and as far as the money, I asked him for that again.

That was about it, because I wanted to come back

and, like I said, get with you, and whenever we decide we're ready. But I do think that the only way I can go in is if I take some people with me. That's it. I mean, we're stronger with numbers than with one person.

So that was it.

CHAIRPERSON OSBORN: Thank you very much. It sounds like a good day's work.

By the way, the letter that Earvin referred to was, I think, the one we wrote after our last meeting with the President, in which we brought home some of the points that had been only briefly touched on in that meeting. I think that's what Earvin hand-delivered, which is very helpful.

MR. JOHNSON: Maybe I said it wrong. When I said a letter, it wasn't exactly the one. What I'm saying is that you had proposed something to him about how much money was needed, so I took that part of it, the need--it had $200 million for this, and so on and so on--and I just took that and put it in the letter that you had already proposed to him, in my own words. So that's what it was. It was your facts and figures, and my words. That's what it was. So I hope everybody got that.

CHAIRPERSON OSBORN: Sounds great.

Roy?

DR. WIDDUS: We are analyzing the available dates, and we'll have some proposals for you in a few minutes.

In order to proceed as soon as possible, the staff need your input on certain specific points so we can continue to move those parts of the Work Plan forward. Clearly, if you go to the memorandum on the Work Plan, it won't be possible this afternoon for you to give your overall blessing to the Work Plan, but I think that could be done, perhaps at the next meeting.

The specific items that we'd like to keep moving forward are those under Points 2, 3, and 4 of that memo on the Work Plan. Clearly, between now and the next meeting when we'll have a fuller discussion, the staff who are working on these various topics will keep you fully informed of what is happening.

A large part of the package that was delivered to you is a very thorough Work Plan for promoting the implementation of the recommendations in "America Living with AIDS" that Tom Brandt and his staff have put together. I think this is a really comprehensive look at how we go about this question of promoting the implementation of these recommenda-

tions. It contains much of the material that you have requested in the past, such as the committees of jurisdiction over specific recommendations; it contains the general strategy, and it contains as Annex 1 to that recommendations Work Plan a list of the 30 recommendations, grouped or clustered by common theme, and it clearly identifies in that matrix the organizations--either the Executive Branch, or the different Congressional committees--that could take action to implement the recommendations.

MR. GOLDMAN: So I can be clear--I'm trying to figure out which document you are referring to at this point.

DR. WIDDUS: The document that I'm referring to is the Work Plan, Attachment 1, entitled, "Recommendations: Work Plan."

MR. GOLDMAN: Okay.

DR. WIDDUS: It's the table that you had in fact turned to. If anyone is not yet at that document, it is a matrix that looks like this. [Indicating.]

MR. GOLDMAN: Thank you.

DR. WIDDUS: I realize there is an enormous amount of information here, and I am trying to guide you to the specific things that will keep the Commission's activities

moving over the next few weeks.

That matrix in the "Recommendations: Work Plan" identifies the 30 recommendations. We would like to set up a conference call between now and the end of January to look at that matrix and to select the clusters of recommendations or the specific recommendations that the Commission wants to pursue most actively, and we'd like to identify how we will pursue those recommendations.

For instance, there are a cluster of recommendations on the financing of care. We suspect that that is a high priority for the Commission to pursue promoting that recommendation.

So the two things that I would like to get some guidance on this afternoon are which individuals on the Commission would like to be part of this conference call where we discuss the priority recommendations to promote and exactly how we go about that. We can fold any number of people into a conference call; it just gets a little bit more difficult to manage.

If any of you are particularly interested, I think we can fold you in.

MR. ALLEN: Could you state that again? On this

document and the priorities of this document, you are asking who wants to be part of a conference call?

DR. WIDDUS: Yes. There are some tentative priorities assigned on that matrix--

CHAIRPERSON OSBORN: Eunice, Don and Harlon all look like they want to say something.

MR. ALLEN: This isn't the vote; this is the discussion, right?

CHAIRPERSON OSBORN: Eunice, first.

MS. DIAZ: Since this is terribly important and also represents our activities over the next six months, year or two years, should we be in existent, it is very difficult to discuss that kind of document over the phone. I am wondering if when you gave those options, you considered if we do have a business meeting in February, could we not do it then, even for the subgroup that wants to discuss it? It is just a little more clear with paper in front of us and with face-to-face interaction, Roy. Probably you had not considered the February meeting. It is very hard to discuss a grid on the telephone.

CHAIRPERSON OSBORN: We've got dates for February, the 19th and 20th. Harlon can't make Wednesday, the 19th,

but could make Thursday, the 20th, according to this note that I have here.

In the meantime, another possibility would be that those who want to get involved in the working through, since the 10th had been available, could do that in anticipation of the 19th and 20th, and do some of the working through beforehand, if that were attractive. That doesn't get tangled--unless David would mind, and Earvin, that would be awfully heavy-duty to put you into, as opposed to if you could make it to the later meeting, after some people have untangled this a little bit. So the two of you who had the problem with the 10th, if you would excuse that, we could ask that somebody do that earlier part of the work instead of on a conference call, as a subgroup sort of thing.

MS. DIAZ: That would be great.

CHAIRPERSON OSBORN: Don?

MR. GOLDMAN: I think I want to volunteer, but I just want to ask so that my understanding is correct--in the memorandum and the recommendations that the working group that I chaired set up, a joint staff-Commission strategic or tactical planning group was one of the recommendations that came out of that meeting, and this sounds an awful lot like

that, and there was a fuller description of the kinds of activities that that group would do. So I just want to make sure we're talking about the same kind of thing that was in fact recommended.

DR. WIDDUS: Yes.

MR. GOLDMAN: I volunteer.

CHAIRPERSON OSBORN: Thank you.

Harlon?

MR. DALTON: I'm sorry, I don't function very well in this kind of thing; it just has me overwhelmed, so frankly, I've just been shuffling through, trying to find the right document. And now that I have my hands on it, I am afraid I missed what it is that this conference call/meeting is about. So just in a couple of sentences--a meeting to do what? This is just not my thing.

DR. WIDDUS: I realize that the matrixes aren't everyone's bread and butter. I'm not particularly keen on them, but it is a way of--

MR. DALTON: I'm not sure I even know what "matrix" means.

DR. WIDDUS: --it is a way of keeping activities moving forward. If you've got that matrix, which has 1

through 30 down the first column, and if you look at the third column where it says "Code," basically, what we need to discuss on February 10 is between the 30 recommendations which cluster in different ways and between the 30 or 40 different targets we could choose for implementing those recommendations, which should get the highest priority. It is looking to some extent at that code, A, B, C, to see whether the Commission agrees with it.

MR. ALLEN: Is there some type of time limitation on some of these that would have to be decided before February 10th--certain meetings or strategies? Do you know if there is something we need to look at earlier than that, or is that going to be all right?

DR. WIDDUS: I think that it won't be an unnecessary delay in the overall activity. We can continue to proceed drafting letters to HHS on the presumption that these things will be needed; if some of it is not needed, then we can put it on the back burner.

MR. ALLEN: Thank you.

MS. AHRENS: Now I'm confused. Some of us are now meeting on the 10th?

CHAIRPERSON OSBORN: I think that would be the next

thing to do, would be to try and get a sense of who is available and interested and so forth. Would you be?

MS. AHRENS: Yes, I would. That's a Monday, so I am here.

CHAIRPERSON OSBORN: So we've got Don, Charlie, Diane, Scott. The 19th and 20th would then be available as two days in which the Commission could follow up on that and/or do some other things if they need to.

MS. AHRENS: So we're to write down the 19th and 20th as a full Commission meeting.

CHAIRPERSON OSBORN: Yes. Write down the 19th and 20th of February. Those are now two Commission dates until you are told otherwise. And then February 10th, for the volunteers that I have already called on, and others. I think people should feel free, if they can rearrange things and want to sign on secondarily; you shouldn't feel constrained because you didn't raise your hand at the right time, but just so that we know we have a core, which we now do, of people.

MR. GOLDMAN: Now, is there agreement that with respect to the two-day meetings, each of the two-day meetings will be preceded by dinner the night before, so when we talk

about the 19th and 20th, we'll be talking also about a dinner on the 18th?

CHAIRPERSON OSBORN: I'm not sure whether, when we have a two-day meeting, we need to be quite so rigid, because we have the in-between evening. It probably depends a little on what is happening on those two days. So I don't think we should be as rigid as that about it. I think when we have a one-day meeting there is just no question that it is very important to have a chance to get ourselves in sync before we go into something that is public. But for the two-day meeting let's leave that a little bit up in the air for a moment.

MR. JACKSON: From what I see here, that's all we have is two-day meetings, so there won't be any dinners.

CHAIRPERSON OSBORN: No. What I was saying was that if we do the two-day meeting, then the evening in between would let us get together.

MR. GOLDMAN: Yes, but originally, when we talked about March 2nd and 3rd, we also talked about meeting on March 1st, the evening before. Why don't we leave those evenings open.

CHAIRPERSON OSBORN: Yes, hang onto the evenings.

Let's assume that we're going to do the dinners before the two-day meetings, too.

VICE CHAIRMAN ROGERS: June, this might be repetitive, but just so I'm sure I know, could I mention the dates we all are blocking out?

CHAIRPERSON OSBORN: Not "all."

VICE CHAIRMAN ROGERS: February 10th--if you can, you do--February 19 and 20; March 2 and 3--forget the evening stuff--April 20, 21, 23, 30; May 18, 19, 21; June 15, 16, 18; July 15 and 16; August 20 and 21. And we'll all be delighted with any that are cancelled, but we'll put those on our calendars.

CHAIRPERSON OSBORN: Right.

DR. WIDDUS: Essentially, we have decided that the working group that will meet on February 10th will discuss the "Recommendations: Work Plan," which is attachment to the Work Plan. Good.

CHAIRPERSON OSBORN: Charlie?

DR. KONIGSBERG: I hate to bring up another scheduling point, but unless it gets changed, the Association of State and Territorial Health Officers meeting is May 17th through the 21st. I can miss a meeting here, but I'm not

going to miss the ASTHO meeting; that's in Hawaii, and that may be changed if everybody's budgets are tight, but as far as I know that meeting is on.

CHAIRPERSON OSBORN: I'm afraid that the process is as far down as we can go, and I don't think we'd be able to back off on that, Charlie.

DR. KONIGSBERG: I just want to note that that is in conflict with a meeting--

VICE CHAIRMAN ROGERS: Some are in conflict with meetings that I have, too, but it just seems we have to do the best we can.

DR. KONIGSBERG: Okay. I just didn't know if that had been taken into account.

CHAIRPERSON OSBORN: Roy is pointing out to me that there are a range of topics that have been brought up by commissioners that have not been dealt with in a hearing format and that might lend themselves to that. The March 2nd and 3rd dates are close enough that if we want to use those for a hearing, we probably ought to settle on something now.

In informal conversation, Roy and I talked about one that sort of jumps out every time you turn around, which is housing in the context of HIV, and one where we tried--and

failed--to get our colleagues in the other Federal departments involved with housing to talk with us about that at a previous time. So in terms of lending itself to a hearing format, not necessarily for two days, but for part of that two-day period, and giving the staff a chance to get the planning done that always takes a fair amount of time before a hearing, that is just one. There is a list on page 2 of the document that has the longer sheets attached to it, if you want to glance down that.

Also, the issue of housing, while it certainly could be dealt with in Washington, D.C., could also be dealt with somewhere else, and that is something to be thought about, too. I continue to make my plea that we remember that the middle of the United States does not know we have an epidemic still, and that we might want to be using a topic like that. I think we'll find that the housing problems are more acute in cities that haven't recognized that they have an HIV problem yet. And March isn't such a bad time in the Middle West to look at housing, because it tends to be pretty cold.

So that's one possibility, and I am just throwing that out to get a discussion started about whether we want to

plan a hearing in March, and if so, do you have other options?

Harlon, Scott?

MR. DALTON: I just want to second the notion that we should get back on the road, it seems to me. Partly, I admit it's a little bit of Washington cabin fever, but I also worry that we're getting a little too Washingtonian, and there's a lot that we can learn by being out and about. And one of the ways in which we reliably have been most helpful and effective is in bringing the spotlight to the places that we go and the work that is being done there. So I don't care whether it's housing or anything else on the list, but I think we need to get back on the road again.

CHAIRPERSON OSBORN: Well, that's a helpful comment, because we might look at locales and think about housing and another topic that particularly fits the locale--something like that--from the list of things that people put forward.

Scott?

MR. ALLEN: If we are looking at housing--and I think we should--we should look at the long-term care as well, and also the transitional care, people falling through the cracks, trying to do step-down programs. It fits very

smoothly into that continuum of how do we house people in various levels of infection and need.

CHAIRPERSON OSBORN: Yes, that's cool, and we could in that context do something that I've thought would be kind of fun to do right along, if you like the idea, and that is to have a playback from the Robert Wood Johnson project, which has now, I think, been evaluated, which was the initial set of looks at the continuum of care concept.

MR. ALLEN: Yes, exactly.

CHAIRPERSON OSBORN: So we could pull in some of the RWJ and HRSA experience as well, but without getting so deeply into it that we can't handle it--but if we make housing a focus instead of health care as a focus.

MR. ALLEN: Yes, and it can move with the health care, also with the public hospitals, people being housed unnecessarily, or those who need that transition, hospice, and so forth. I think looking at it from that type of mind-set I think would be very helpful to us all. Also, let's get HUD.

VICE CHAIRMAN ROGERS: Yes, that's neat.

Irwin?

MR. PERNICK: June, I very much like the idea of

the discussion of business and professional interests, although it need not dominate an entire meeting. I think it would be useful to invite the Chamber of Commerce and maybe the National Association of Manufacturers and groups similar to that to come in and discuss the problem, and not necessarily be confronted by us, because I think they'll be a little defensive. But it would be interesting to hear what they have to say and what they have done with their membership. And it doesn't have to be in March; it could be later on.

CHAIRPERSON OSBORN: Thanks. That's good.

Don?

DR. DES JARLAIS: Because being on the Commission is driving us all crazy, I would argue for mental health as being one of the issues we discuss--that's only semi-seriously on the first part. But I think mental health is really something that we pretty much skimmed over in the first two years and that is becoming more and more of a problem as health care workers burn out, and the disease is spreading very rapidly among people who have psychiatric problems.

CHAIRPERSON OSBORN: Good thoughts. It sounds like there is some good consensus about the general themes that could be picked up, and some of that will probably have to be

opportunistic depending on who is available and where the beset site is that can respond fairly quickly, because we're still talking just a six- or seven-week turn-around, and that's not a lot of time to plan something, particularly on the road.

Don, and then Diane.

MR. GOLDMAN: I'd like to suggest that in my judgment, if HUD is not willing to seriously participate in a discussion on housing, then we ought to very carefully think about how we want to deal with that refusal strategically. Maybe having a hearing without them is the appropriate thing, but maybe some other mechanism--

CHAIRPERSON OSBORN: But to be fair, it is two years ago that we invited them, and I have no reason to think they won't be interested in talking to us now. We were just "spring chickens" at that time.

MR. GOLDMAN: I would argue or suggest that given the fact that Congress funded for the first time the AIDS Housing Opportunities Act, and HUD has indicated that the regulations may not be ready before the end of the fiscal year, indicating that $50 million will simply be not spent on an issue that Congress has appropriated, give me reason to

believe that two years ago, HUD's refusal to come before the Commission reflects an attitude that has not changed. And I just want to say that that is a factor that I would urge be taken into consideration before scheduling any hearings.

CHAIRPERSON OSBORN: I had said Diane next, but Jim, did you have something specifically on that point?

DR. ALLEN: Don, later this week we're having an interdepartmental meeting that is going to be held at HUD with a number of HUD participants explaining their programs and describing them. We have invited Roy and any of the other Commission staff, and certainly any of the commissioners that would like to come.

I think that you will find a very different attitude now and that HUD will very willingly come and explain programs and discuss the issues with you. There are a number of people at HUD that we have met who I think are very concerned and very involved, and I think you will find a very different attitude.

MS. AHRENS: Just to verify what we all know--that not all programmatic wisdom comes out of Washington--there is an awful lot being done at the local level across this country to put packages together on housing kinds of propo-

sals, and I think if we are out in mid-America or wherever, we could pull some of those people in. The Conference of Mayors would have information to pull in, to find out how this is being done without the help of much Federal money.

The other thing I want to support is this business of going out into the country. It seems to me that at least 50 percent of our meetings--and I said this two years ago, so I sound like a broken record--ought to be held outside of Washington. I think it does so many things that we all agree are important. So I hope we have that as a goal, that at least half of our meetings are held outside of D.C.

CHAIRPERSON OSBORN: Okay. I think all of that gives a lot of good guidance to the staff to start working for an interesting session in March. And we'll try to make a fairly quick decision about what locale lends itself to bringing out the optimal number of themes with the short turnaround and so forth, but it does sound like it could turn into a very rich hearing.

I think that's all the business you needed to conduct for the moment, urgently.

DR. WIDDUS: The only other item I would bring to your attention is a memorandum distributed to you on the

Social Security Administration proposed changes in the AIDS definitions. If you think that we should submit any comments on that, those could be transmitted back to the staff. I believe that the closing date is sometime in February for those. Please check the memo as to when the closing date is.

CHAIRPERSON OSBORN: Harlon?

MR. DALTON: I haven't looked at the memo yet, but is there a recommendation from the staff about what we should do about the proposed definition?

CHAIRPERSON OSBORN: I don't think we've solicited recommendations, so there probably isn't one. We could if you'd like, Harlon--is that what you're saying?

MR. DALTON: I just think that if the staff have looked at this, I'd be interested in their thoughts.

CHAIRPERSON OSBORN: Maybe we can look at that as a request.

DR. WIDDUS: I'll be honest--we haven't looked at it, either. Really, we could sit down and analyze it. We know there are concerns in the affected community remaining about these proposed changes in definition. We don't know--we haven't assessed yet whether those concerns are of sufficient legitimacy and magnitude to warrant a Commission

submission on this.

CHAIRPERSON OSBORN: Eunice?

DR. WIDDUS: Roy, did we get an answer back from CDC regarding our request to them on that?

DR. WIDDUS: The CDC did in fact extend the comment period on the proposed changes in the AIDS case definition. I had a number of conversations with the CDC people who were looking at the definition. They are going through a process, now and for the next few days, weeks, of drawing in more groups to discuss with them the implications of the definition.

So I think the Commission did something very useful there in broadening the CDC process and pointing out to them--and they agreed to follow up on this--pointing out to CDC a number of instances where it was more a matter of clarifying the way they thought certain things would actually come about, things like the reporting mechanisms, clarifying that some of the confidentiality concerns were not exactly as stated because of the way in which laboratory reporting, for instance, operates.

We have not proposed to CDC anything specific other than extending the comment period and making the rationale

behind their decisions clearer. That in itself, they agreed to do, and many groups in the community felt that that was a good action on the part of the Commission, that it did something which was beneficial in the long term.

MS. DIAZ: But they didn't say for how long.

DR. WIDDUS: Tom, can you remember when they extended it to--

MR. BRANDT: It's a 60-day extension.

DR. WIDDUS: Thank you.

MS. AHRENS: Madam Chair, I know really nothing about the SSI eligibility criteria, except that this is--I did read part of this, and it's the most obscure document that you can imagine--but it is a very important issue--I think it is a very important issue--and the Commission clearly ought to address it because it will affect so many people that we care about.

I don't know, unless we get some kind of analysis--those of you who do understand what the changes in the definition mean need to lead us here. Somebody needs to lead us, and I think we should respond to this.

CHAIRPERSON OSBORN: That will get done quite quickly now. It wasn't something that got done for this

Commission hearing, but it will be done soon.

MS. AHRENS: And Madam Chair, in the responding, I think it is terribly important when letters like this one or the one that went to the Centers for Disease Control go out, that everybody should be called and polled on it; I think we all should have some input into it. Those are very important kinds of issues because they affect so many, really, thousands of people.

CHAIRPERSON OSBORN: Yes. Whenever that is possible without missing a deadline, I think that has been the Commission policy. The one exception that you mention had some time pressures, as I recall, but that is certainly our hope and policy.

Harlon?

MR. DALTON: Back to the Social Security Administration change in the definition of disability, I did read up on this before our last meeting, and if I have any residual brain cells from that, maybe I can jog them--and if so, I'd be happy to pitch in on this. But my question is--is this proposal the same as--prior to the last meeting, the Commission had available to it a draft document of the proposed changes, and my question is is this the same--

MR. GOLDMAN: No, there was no such thing. It didn't exist. They refused to announce it at that meeting.

DR. WIDDUS: There was a draft available, but that was an informally-circulated draft.

MR. GOLDMAN: Okay.

DR. WIDDUS: What you have in front of you now is the specific proposal that has been published in the Federal Register--

MR. DALTON: I understand that. I can see that.

DR. WIDDUS: To your specific question, I think there are differences between the two things, but I'm not sure exactly what.

VICE CHAIRMAN ROGERS: Just a point of information for the Commission. You may recall we've been back and forth with CDC about HIV testing in the health care setting. My feeling is they have been quite responsive to our concerns. That, as you know, has been pulled back and is still in the making. It is my fond hope that they are going to come out with something that is really much more in line with what our original hopes were.

DR. KONIGSBERG: Just a comment on that. Probably by the time CDC comes out with what we're all happy with,

virtually every State in this Nation will already have something done. That's happening in my State now, and I think that it is going to be a bit too late.

VICE CHAIRMAN ROGERS: Maybe. My fond hope is they follow New York State or San Francisco.

DR. KONIGSBERG: Actually, we're following Michigan interestingly enough.

VICE CHAIRMAN ROGERS: Or Michigan. Fine. Any one of the three is fine.

CHAIRPERSON OSBORN: Okay. With that, I think we've exhausted ourselves--I'm sure we've exhausted ourselves--and I was remiss at the beginning of the meeting in not mentioning the extraordinary extra effort of the staff and of the Health and Human Services Department in letting us actually function here today. It looked at the beginning of the day as if there was absolutely no way that things could function, and if anybody ever says things can't happen fast in Washington, you should remember this historic day.

Jim, in particular I think the National AIDS Program Office had lots to do with the fact that it worked, and in addition if you would convey our great gratitude to Dr. Mason, Dr. Sullivan and the Department for putting up

with all of this--it has really been a wonderful venue, so thank you for that.

And to staff--I said this at lunch privately, but I want to say it publicly--we really have the best Commission staff that anyone could have. This has really been an extraordinary hearing and under duress. So thanks very much to Roy and the staff for that.

And Roy, you get to adjourn these things because you are the government employee.

DR. WIDDUS: As the Staff Director, I want to say that everyone on the staff put in an enormous effort to get this hearing set up. It was not the same as most of their other hearings. You have seen the amount of documentation that has come out through staff on the proposed Work Plan.

I just want to thank the staff for supporting me and doing as much as they have done, and thank the commissioners for their tolerance and patience of anything that wasn't quite perfect today.

Thank you.

[Whereupon, at 4:17 p.m., the proceedings were concluded.]

C-E-R-T-I-F-I-C-A-T-E

I, Annie Hayes , the Official Court Reporter for Miller Reporting Company, Inc., hereby certify that I recorded the foregoing proceedings; that the proceedings have been reduced to typewriting by me, or under my direction and that the foregoing transcript is a correct and accurate record of the proceedings to the best of my knowledge, ability and belief.

Annie Hayes