ORIGINAL

TRANSCRIPT OF PROCEEDINGS

NATIONAL COMMISSION ON

ACQUIRED IMMUNE DEFICIENCY SYNDROME

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SEX, SOCIETY AND THE HIV EPIDEMIC

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Pages 166 thru 322
Volume 2

New Orleans, Louisiana
May 19, 1992

MILLER REPORTING COMPANY, INC.
507 C Street, N.E.
Washington, D.C. 20002
(202) 546-6666

NATIONAL COMMISSION ON AIDS

SEX, SOCIETY AND THE HIV EPIDEMIC

Ballroom
Le Meridien Hotel
614 Canal Street
New Orleans, Louisiana

Tuesday,
May 19, 1992

The above-entitled matter came on for hearing, pursuant to notice, at 9:00 a.m.

PRESENT:

JUNE E. OSBORN, M.D.
MICHAEL R. PETERSON, M.P.H., DR. P.H.
JAMES R. ALLEN, M.D., M.P.H.
DONALD S. GOLDMAN
EUNICE DIAZ, M.S., M.P.H.
SCOTT ALLEN
ROY WIDDUS, PH.D.
DAVID E. ROGERS, M.D.
HARLON L. DALTON
DIANE AHRENS
DON C. DESJARLAIS, PH.D.
LARRY KESSLER
SHEILA WEBB
THOMAS J. COATES, PH.D.
JOHN H. GAGNON, PH. D.
VICKIE MAYS, PH.D.
VINCENT BRYSON
TOM BRANDT
FRANCES PAGE
IRWIN PERNICK
JOHN MONEY, PH.D.
CAROLE VANCE, PH.D., M.P.H.
JOSE PARES-AVILA, M.A.
RICHARD GREEN, M.D., J.D.
PRISCILLA ALEXANDER
WALTER SHERVINGTON, M.D.
ROBERT SELVERSTONE, PH.D.
PEDRO P. ZAMORA
TIM H.
DR. HYSLOP
FRANK AQUENO
MARK DURHAM
DR. SUSAN ABDALIAN
CORNELIUS KING
PATRICK LEBLANC
NORMA PORTER

I N D E X

PROCEEDINGS

DR. OSBORN: Let me thank all of you for coming. And do we need to have any other business before we proceed?

(No response.)

DR. OSBORN: I think what we often like to do with this kind of -- when we have this kind of collection of talent is to hear in sequence each of you so that we have the full benefit of your input and then have as much time as possible to interact together afterwards. So those of you who have written statements for us, the commissioners are really quite good about reading those, and if you find that it is better to use a short period of time to summarize or to say even other things, that is fine; and then with luck, we will have a good chance for discussion after everyone has had a chance to speak.

I think also I may ask that each of you introduce yourselves as you, since if I do it all now, by the time we get to the fourth or fifth person, nobody will remember.

So Dr. Money, in the order of the agenda, if I could ask you to start. Thank you for being with us and welcome.

DR. MONEY: Thank you and good morning. I am John Money from Johns Hopkins University and Hospital,

where I am now emeritus professor of medical psychology and also emeritus professor of pediatrics. I am going to have my remarks today set in an historical context and bringing history up to the present.

American society today is indeed hamstrung in dealing with everything related to sec and HIV because here we are in the midst of a sexual counter-reformation, as I like to say. This counter-reformation began in the late 1970s. Thereafter, anti-sexualism cascaded into prominence as a reaction to the so-called sexual revolution which I think really should be called a sexual reformation -- and this reformation or revolution had begun in response -- I think it is really important to understand the fact that revolutions just don't come out of the blue.

But it began in response to the marketing of penicillin for the prevention of syphilis and gonorrhea, and that really didn't get underway until the very late 1940s and 1950s, and the revolution or reformation continued further in response to the marketing of the Pill, which began in 1960. The Pill wasn't new as a contraceptive, but it was extremely new as a highly effective contraceptive for women, and as I have found from many years of talking to many people in audiences and alone, the most important thing about the Pill was that

you put it in the top end of the body instead of the bottom end, and you put it in in the morning instead of at night, so that you were able to dissociate the spirit and the flesh, so to speak.

Now, the sexual policies and doctrines of the counter-reformation were, pretty obviously, set in place before the new viral disease of AIDS was first identified in 1981. As a matter of fact, there was a famous cover of Time Magazine dealing with herpes virus and announcing that the sexual revolution was over.

So the policies of the counter-reformation -- I think they were actually engineered, but I am not sure by whom, but they were borrowed directly from 19th century Victorian anti-sexualism, and this Victorian anti-sexualism was based historically on the totally erroneous conception which dates all the way back to at least 600 B.C. -- and probably very much earlier in oral traditions in Indian and Chinese medicine -- and this erroneous conception was of the terrible consequences of losing the vital fluid, of which the most important of all was semen.

It put women in a terrible position because they were so stupid they didn't even have any vital fluid to lose, and believe me, that philosophy has handed itself down into the present day as one of the very basic

underpinnings of the differences between the sexes. But that is a little beside the point.

What I want to say is that Victorianism was based historically on this totally erroneous conception as applied to the social disease; and the social disease, as we now know, was actually considered in those days as syphilis and gonorrhea combined, and it was attributed as caused by the wastage of the vital fluid, semen. The most important author for that was Sigmund Andre Cleseau [phonetic] in Switzerland. His book came out in 1758 on the terrible consequences of the diseases caused by onanism, which today, of course, we would call masturbation.

This wastage was attributed not only to the social vice of promiscuity -- and let's remember the germ theory in microbial contraction of disease were not discovered until the 1870s. So it was not only promiscuity and whoring that syphilis and gonorrhea were attributed to -- which, of course, was completely correct -- but in addition, what happened was one of the most colossal intellectual errors of modern medicine -- maybe of modern science -- and that it was attributed also the loss of vital fluid through the vice of masturbation, the secret vice. The social vice and the secret vice, therefore, were combined as a source of absolute terror

that dictated the entire policy of Victorian morals for over a hundred years, and it continued in the Boy Scouts Handbook until the 1940s.

I always rather like to remind myself and audiences, too, that the secret vice of masturbation means in Latin "hand rape," but I am never quite sure whether the hand is raping the sex organs or the sex organs are raping the hand.

Masturbation is no longer, of course, regarded as a dangerous disease, but its legacy of profound anti-sexualism still persists. It persists so effectively that it paralyzes religious, political, and legal rationality in response to the problems of sex, society, and HIV. Masturbation, including mutual masturbatory massage is the only form of safe sex, the only form that can be absolutely and unconditionally guaranteed to prevent the transmission of HIV.

No matter how good the intention, even if the spirit is willing but the flesh is weak, abstinence and chastity may fail. I think it is very important, to me anyway, to emphasize that we are not able to accept the safety of masturbation because we are still under the Victorian shadow of not being able to accept masturbation itself.

Especially in youth, however, the surest way to

escape personal sexual contagion with HIV is to know not only what is not safe, but also to know what is safe; and moreover, and especially, to be able to know about it and talk about it right out in the open, overtly and explicitly with your family, with your teachers, with your preachers, with everybody: no holds barred and no pussy-footing. It must be, and it must become a topic in the public domain, which means it must be discussible and visible on television.

I know that what I am already saying and am about to say further will be heard as a secular heresy in the eyes and ears of those who would adhere to the principles and practices of the sexual counter-reformation. Nonetheless, I must say it, otherwise like Nero fiddling while Rome burns, we will continue watching our nation self-destruct as our youth are sacrificed to the monster of AIDS. I have an image of Andromeda being chained to the rocks for the sea monster, except that we are chaining our youth to the rocks for the monster of AIDS.

My secular heresy is that we should embark on a nationwide program, equivalent in magnitude to the Manhattan Project or the Marshall Plan to eradicate anti-sexualism from our midst and to replace it with a positive philosophy, or as I much prefer to say, not philosophy but

sexosophy, and it would be a sexosophy of pro-sexualism.

This change will require charismatic leadership, and it will require involvement in leadership and followership from the grassroots up, and it will apply to all segments and all institutions of society. It will require also maximum use of the media, especially television, because of its extraordinary power to reach tens of millions of people.

There will be special television channels designated as specifically sexual and erotic. They will combine sexual news and information, medical and scientific, or of any other sort, and it will combine it with erotic entertainment of the highest caliber: nothing sleazy. The programs will be designed so as to provide material that will teach as well as entertain viewers of different positions according to age, sex, intellect, maturity, cultural heritage or other criteria.

It will explicitly promote that which is safe in sex instead of chastising only the negative; thus, it will actively demonstrate the safety of masturbation. This idea is one that derived from something I heard of many years ago in Amsterdam when the way to get the hippies from the Londervogel [phonetic] Park into medical care when they had sexually-transmissible diseases was through a community center, and it had a theater and it

showed sex movies, and it was very effective at bringing people in and getting them treated.

So even for pre-pubertal juveniles, we will have to reach a stage in which there will be none of the euphemizing and evasiveness that is today so complete that all across the nation there is not even one clinic, not even one clinic that specializes in pediatric sexology and sexual health, and that happens to be true all over Europe and the rest of the world, too.

But what is even more amazing to me is that the same applies that there is not even one clinic that specializes in adolescent or, in other words, ephebiatric sexology and sexual health. It is an extraordinary accomplishment in wearing horse blinkers, I think.

Pre-puberty is the age when explicit sexual and erotic information can be assimilated intellectually without the distraction of genital arousal, and I have found in the clinic that it is very effective to get basic ideas, including ideas of safe sex, across to young people before they are at the stage of puberty and the hormonal genesis of erotic arousal at its full peak.

Then post-puberty, in the early years of adolescence, it is this very distraction of being so easily erotically aroused that can be channeled exquisitely into approved safe-sex practices, which would

include masturbation to begin with. One can imagine a graduated series of behaviors so that later on young people graduate to a safe-sex contractual agreement with a partner and the vow of reciprocal fidelity.

Although I have called my proposal a secular heresy, there is nothing in it that is entirely new. It is a composite of concepts and practices that have indeed been carried out piecemeal either by subgroups within our own society or else can be viewed transculturally. Taken as a composite whole, however, this -- these ideas represent a fundamental change in our national sexosophy. Let me just add that sexosophy is the philosophy and the morality of sexuality and eroticism, whereas sexology is the science of sex.

The new sexosophy that I am calling for should release much national debate, for it necessitates a revision of virtually everything in our present sexosophy. Nonetheless, it is time to begin. Even after an advance in medical technology provides a method of eradicating the AIDS virus, as it is expected eventually to do, HIV eradication worldwide will not be possible without individual cooperation.

People, however, will not and do not cooperate in matters of social sexology unless they are emancipated from a negative social sexosophy like the one under which

sexual practices are stigmatized and chastised, which, of course, is exactly what is happening in our midst today, particularly as it applies to youth.

Thus, it is, indeed, in the interest of national self-survival that in American sexosophy, today's heresy becomes tomorrow's orthodoxy. Thank you.

DR. OSBORN: Thank you very much.

Dr. Vance, could I ask you to go straight ahead, and please do introduce yourself.

DR. VANCE: I am Carole Vance. I teach at the School of Public Health at Columbia University, and I am an anthropologist with another degree in epidemiology.

DR. OSBORN: You may need to lean a little closer to the mike.

DR. VANCE: My job was to examine the influence of culture on sex in America in the past hundred years --

DR. OSBORN: We are really kind to our guests.

DR. VANCE: -- a succinct history. What I would like to do is to concentrate on several points that have always struck me as very interesting: One, the tremendous paradox in public-policy discussions about sexuality. At a time when pleasure is an increasingly legitimate and accepted dimension of the way people experience sexuality in their personal lives, sexual pleasure is virtually unspeakable in public-policy

discussions, except as something to be denounced.

Second, the way in which an old cultural narrative which suggests that sex equals death -- that is, in a religious narrative, sin or spiritual death -- can be revived in recirculated in public-health discussions in a new and very effective way.

Third, the centrality of what historians call "panics" in shaping sex policy and law; and fourthly, given very profound post-World War II changes in gender, family, and social arrangements, the likelihood that HIV prevention which does not address sexual pleasure will fail.

Now, you have already heard some background yesterday about the broad question of sexuality and culture. What we know about it, I think, is that sexuality is not a narrowly-constructed biological impulse as our folk culture tends to see it. Sexuality is about human meaning and human arrangements.

Even early in the 20th century when anthropologists began to document cross-cultural diversity, that is the fact that humans had widely-varied sexual customs and attitudes we began to see that childhood masturbation was seen as normal in one culture, but severely punished in another, or that premarital sex was reprehensible in one group but desirable in another.

In those early decades, it seemed that culture was something like a traffic signal, issuing yes and no commands to a range of behaviors we saw as sexual in our own society.

Since then, in the past 20 years, we have come to see that the influence of culture on sex is even more profound. Since culture provides the frame through which we and every other human group first defines and understands what sexuality even is, culture provides sexual meaning, and the same physical act which can have widely different meanings in two different cultures or even in one culture at a hundred-year period distance.

By sexual meaning, I mean what is sexuality? What parts of the body are sexual? What does it say about the person who performs a sexual act? What is a sexual act? What rules do members of the culture use to interpret sexual interaction? And in complex societies such as ours, how is sexuality mediated by gender, by social class, by race, and sexual preference.

So from all this, we understand that sexuality has a history. It is changeable and changing, and that this history is rich in meaning and symbols. The symbols are both visual and verbal, which people use to express both implicit and explicit messages about sexuality. Given this background, what do we know about the history

and culture of sexuality in America, and more broadly speaking, English-speaking countries, that would bear on the unfolding of the HIV epidemic and responses to it.

And here I would like to concentrate not so much on studies about individual behavior or attitudes in this decade or that, but look at a very broad and symbolic matrix in which public discussion about sexuality takes place.

First, I think we would have to say without question that this is a culture that has profound ambivalence about sexual pleasure. Some have linked this to a Calvinist or Puritan suspicion about all pleasure, and a preference for emphasis on work, competition, and achievement rather than sensory enjoyment.

But even so, it seems for us more possible to conceptualize other nonsexual pleasures as nondestructive. On a deep symbolic level, sexual pleasure has been, for over a hundred years, linked to excess, irresponsibility, self- and social destruction. Ironically, this conceptualization leads to the setting up of special sexual "pleasure zones": geographies in cities, special times in one's own life, characterized by -- which are characterized by and tend to evoke the very sexual irresponsibility that the culture fears.

So over this hundred-year period, we see a

profound cultural conversation: Can sexual pleasure happen without destruction?

The second major feature I would like to call your attention to is a massive shift that has taken place in the past hundred years in which what had been an absolute linkage between sexuality, procreation, and marriage was first loosened and then broken; that is, it is increasingly possible and increasingly common for people to have sex without it leading to procreation or to marriage.

We see this shift first in middle-class married couples at the end of the 19th century as they begin to use birth-control techniques as they become available. We see that progression move from the elaboration of non-procreative sex within marriage to then move out among -- to non-procreative sex among premaritally-active heterosexuals, and then among gay men and lesbians.

These developments, I am arguing, are linked. What happens in heterosexuality is organically related to what happens in homosexuality. Put simply, the prime 19th century rationale for intercourse, procreation, is replaced by other goals: intimacy, pleasure, emotional satisfaction; and these changes are supported by a new growing sexual culture, a folk culture, a popular culture, and to some degree cultures in biomedicine and sexology.

We would see the shift somewhat as private as couples make decisions in their personal lives. Yet, it is also true that these transitions are marked by public and vociferous debate, as law and policy become the arenas in which political, professional, and moral groups argue about the desirability or undesirability of breaking the link between sexuality and reproduction.

These debates obviously haven't disappeared; they are continuing today. But they have moved to different locations, and the movement of this debate, I think, just indicates how acceptable sex for non-procreative reasons has become in many other areas of life.

A related development to this is the appearance and elaboration of a concept in autonomous female sexuality. That is something very much in contrast to a 19th-century concept in which women were seen as either intrinsically asexual, having no sexual desire or capacity or sexual pleasure, or their sexuality was very narrowly conceptualized as equivalent to motherhood. I think we would see this as an incompletely-realized development that is still happening, but that is certainly part of the picture.

The shift in sexuality is also reflected in the development of a new standard to evaluate appropriate and

ethical sexuality. The older religious standard viewed any sexuality which did not lead to procreation as sinful, and hence, unnatural, and this criterion remains the basis for much sex law on the books, which tends to be the most archaic and slowly-changing area of our culture.

But with the proliferation of non-procreative sexuality, a new criterion began to emerge, one based on the idea of consent. Relationships or actions were ethical if both parties consented to them; force and coercion, by contrast, were not. Now, let's just note that these two criteria actually are both circulating: an older standard of procreation, a new one of consent.

We can see the effect of the doctrine of consent in, for example, a recognition that such a thing as marital rape can occur, and in many states has now been criminalized. And we can also see it in our reaction to a situation described by a 17th-century observer. He thought that rape, although sinful, was still less unnatural than masturbation, which at least -- that is, rape -- contained the promise of procreation.

Fourthly, I think we need to consider the role of the growth of biomedicine and science as authorities in sexuality: the movement away from religious and ethical control over sexuality. Biomedicine at first promised more scientific and rationale knowledge, and sometimes

more humane treatment as sexual deviants were to be treated as people who were sick rather than evil or sinful.

This is a very complicated history, but I think it is important to note that increasing governmental interest and action on health issues having a great deal to do with sexuality, even by the late 19th century, coupled with the medical profession's claims to knowledge and efficacy in this area made public health an important arena in which sexual issues were discussed: Venereal disease, prostitution, the eugenics movements, birth control, abortion, and so on have all been public areas of controversy where these medical ideas have been worked out. Now, it is clear, I think, that these newer scientific discourses indeed made judgments about health and normalcy, often using older standards of naturalness, i.e., procreation.

Finally -- and this is something I think we need to take to heart and probably you in your own work have experienced indirectly if not directly -- all English-speaking countries are very vulnerable to something historians call "sexual panics," which prove very influential in shaping policy and law.

Sex panics seem to happen in times of great change in gender arrangements, family, masculinity and

femininity, in which a great deal of social anxiety of floating and gets crystallized and projected on a specific sexual event. These sexual panics are quite episodic. They seem to come out of nowhere. They usually start with a sensationalist report: in the 19th century in the cheap penny tabloids, now in electronic media, of a sex crime, a sex scandal, or some kind event. Sometimes it is real; sometimes it is highly fictitious.

These reports evoke great public concern and even hysteria. Citizens issue agitated and emotional proclamations. Politicians and legislators jump on the band wagon, some out of sincere concern, many out of self-advancement and opportunism. The public emotion has the quality of a tidal wave. Before it subsides, laws are passed which frequently remain on the books for 50 to 100 years, and it is something I think historians and even anthropologists don't understand adequately, but there is no question that all English-speaking countries have been marked by period episodes of these sexual panics.

Finally, we come to the paradox. Given this history of an enormous disjunction between what people often experience and think about their private lives, that pleasure and sexuality is a reasonable goal and does not lead to personal self-destruction, and the rhetoric that can be used in public-policy discussions.

As a result, policy discussions about sexuality are frequently framed as a conversation between moralists whose goal is to use the negative disease consequences or even death linked with sexuality to reinstate the link between procreation, marriage, and sex. That is one side of the equation; and public health and biomedical officials and educators on the other side whose goal, of course, is to reduce death and disease but for fear of being branded immoral or caught up in these sexual panics or unwilling to discuss sexual pleasure, either as a reasonable motivation for individual behavioral change or as an experience that good public sex education should try to enhance.

Now, although this dynamic has a long history and although it is very deeply embedded symbolically in the visual image we are accustomed to seeing and the rhetoric that gets used in public conversation, I would argue that it is not a culturally viable one any more. I think this is a very critical moment, obviously because of the seriousness of AIDS, but also because of the profundity of social rearrangements in gender, in family, in people's actual expectations, in shift in the public culture and popular culture where the public, I think, is genuinely interested in useful information that assures them that sexual pleasure that can be achieved in a

responsible and healthful is an important public goal which they would gratefully receive more information about.

DR. OSBORN: Thank you, Dr. Vance.

MR. PARES-AVILA: I am Jose Pares-Avila, and I am a clinical psychologist fellow at Harvard Medical School, and I work as a psychotherapist at Massachusetts General Hospital in a specialized unit that offers psychiatric care to people affected by HIV, and my patients are primarily gay men.

It is an honor to be here with -- before the commission and with such distinguished witnesses, and when I get -- my invitation came totally unexpected to me, and I feel quite nervous about how to make the best use of my time, but I felt much more competent after listening to Dr. Mays and Dr. Gagnon yesterday, because I want to piggyback on some of the issues that they raised.

I want to spend my time addressing issues affecting a group that has consistently fallen through the cracks when it comes to HIV prevention, and that is gay men of color: gay and bisexual men of color. Given my knowledge base and my experience, I will limit my comments to Latino gay and bisexual men.

I must confess that I feel somewhat disadvantaged in speaking about these issues. When a

social scientist gets the opportunity to present before such an influential policy-making group, he or she wishes only to make sound recommendations that can be backed up by a solid body of scientific literature and a strong data base to make reference to.

When it comes to homosexuality and bisexuality in the Latino community, the literature is scarce, and the data are nearly nonexistent, with a few exceptions that are worth mentioning, such as ethnographic with Mexican men conducted in southern California by Drs. Margania [phonetic] and Carrier, the focus groups with Latino gay men conducted in the northeast, in Puerto Rico, and in San Francisco, and the Latino gay men's pilot project that I conducted for the Latino Health Network in Boston.

What I can say about homosexual behavior in the Latino community comes mainly from clinical and anecdotal data as well as these small but pioneering research endeavors. The writings of some gay and lesbian clinicians and scholars of color have also helped me to gain some understanding and articulate the complexities of sexuality and Latino gay men.

I will make available to the commission a manuscript on these issues that I co-authored with my colleague Ruben Montano [phonetic] that will appear next year in a book to be published by the American Psychiatric

Press.

Although this is a good start that can take us in the right direction, the data available on the sexual behavior of gay and bisexual men of color are limited and will never compare with, for instance, the national data set on the sexual behavior of injection drug users and their partners gathered by NIDA [phonetic] in their national demonstration projects or the cohorts of mostly Anglo gay males available in cities like San Francisco, Los Angeles, New York, and Boston.

Nevertheless, what is available can help the commission in identifying a serious knowledge gap by making a very crucial and top-priority recommendation: We need to start from square one in terms of funding basic sex research that will broaden our horizons beyond Anglo middle-class values and norms in order to halt the spread of HIV among men of color.

We know for a fact from looking at CDC surveillance data that the majority -- and that is 51.1 percent -- of Latino AIDS cases are gay and bisexual men. These figures come from adding up those men whose self-reported homosexual behavior as well as those who have reported both homosexual and needle-sharing behaviors.

The relative risk of a gay male to have -- of a Latino gay male to have AIDS is almost twice that of an

Anglo gay male. It is interesting and noteworthy that these relative-risk figures change when you compare US-born Latinos and foreign-born Latinos to Anglo males. While a US-born Latino is 1.1 times more likely to have AIDS, these figures are 4.9 for a Cuban-born man, 2.3 for island-born Puerto Ricans, and 3.3 for other Latin-American-born men.

These between-group differences raise some interesting points as well as research questions. Number one, these differences indicate how critical it is to use adequate ethnic identifiers with studying Hispanic populations with different national and ethnic origins, and that is something Dr. Mays brought up yesterday in terms of race and ethnicity in research.

Number two, these differences indicate that foreign-born Latino men are probably less likely to be reached by current HIV-prevention efforts; and number three, in terms of future research, these differences raise questions about the potential role of acculturation in AIDS-related knowledge, attitudes, and behaviors.

These data reflect only Latino men who self-identify as gay or bisexual and do not include heterosexually-identified men who have sex with men; and to give you an example of that, results from the HIV blood-donors study group showed that among the 209 serum-

positive male blood donors who reported unprotected anal sex with another male, Latinos were more likely to self-identify as heterosexuals and to report a female partner as their primary sex partner.

What do all of these epidemiological trends mean? They are just a head count. We don't know what they mean, and there is no research to investigate what it means. They strongly support my earlier point of Latino gay and bisexual men falling through the cracks and the importance of making them a priority population in future prevention efforts.

When it comes to AIDS prevention in Latino communities, we have seen a great deal of attention going in to injection-drug users and their partners. To date, the media continue to maintain the belief that Anglo gay men and minority IV use are the two most affected groups. We hear about the worrisome rise of heterosexual transmission among primarily people of color, and at the same time, we hear about the tremendous success of the San Francisco model and its clones all over the country.

The gay community is looking now at relapse prevention as we enter the second wave of the epidemic. What is wrong with this picture? Well, Latino gay and bisexual men were never reached by these efforts, and we have never seen slower infection rates, as was seen in the

Anglo gay community. The disproportionate rates that I mention have been consistent for the past eleven years.

Some of the reasons why Latino gay and bisexual men continue getting infected are related to critical demographic, cultural, and socioeconomic differences. The impact of cultural beliefs, attitudes, and values are crucial in the social construction of homosexuality, and they must be studied systematically as we attempt to develop adequate HIV-prevention strategies.

When addressing the needs of Latino gay men in HIV prevention and intervention, we must take into consideration the multiple dilemmas faced by them when they attempt to embrace aspects of themselves which are stigmatized by the dominant culture because they are Latino -- and as well as their community of self-origin because of their homosexuality.

They must deal with "coming out" or remaining closeted within a homophobic Latino culture which is caught up in their own struggle for survival in a racist and classist society. For some, the natural choice is to seek refuge and acceptance within the gay community; however, they quickly find themselves between a rock and a hard place when many of them realize that the racism and classism seen in society at large permeate the values and attitudes of the Anglo gay community.

For others, the choice may be to lead a more closeted gay lifestyle in order to protect their ties to their families and their communities. Such is the choice of many self-identified Latino gay men who give priority to maintaining their connections to the Latino community. These men may have a more marginal relationship with the Anglo gay community, which is probably limited to some participation in their social structures, like going to gay bars and refraining from participation in the political structures, such as gay-identified AIDS-service organizations.

These men are perceived by the activist sectors of the gay community as too closeted for the advancement of gay civil rights. Thus, Latino gay men constantly face an array of difficult dilemmas and choices. In the social and interpersonal arenas, they have to choose or go back and forth between opposing cultures in order to satisfy their needs for friendships, love, nurturance, and intimacy. In the political arena, Latino and gay civil rights pull the Latino gay men from all sides and creates a sense of divided loyalties.

To illustrate some of these points, I want to share some finding from my pilot study of Latino gay men in Boston. Nearly half of the sample have never volunteered in a gay-identified organization, and more

than half -- 68 percent -- have never attended a local AIDS walk in Boston. More than half, or 53 percent, have never attended a gay political rally, and 41 percent have never attended a Gay Pride parade. All of these activities are vehicles that have empowered the Anglo gay community in their fight against AIDS, and have helped to promote and maintain behavioral change.

What makes these findings striking is that the sample consisted of mostly well-educated, middle-class Latino gay men who were fully bilingual and held professional jobs. The majority also reported being in relationships or dating primarily Anglo gay men. You would assume that they were pretty well integrated into the gay community and that they would be enriched by the prevention efforts, and indeed, there were worrisome findings in terms of their risk, behaviors, and their knowledge.

If this is the case with such a group of gay men, imagine what it would be like to see what the risk behaviors are for Latino gay men who are recent immigrants, who speak very little or no English, and who are at a more disadvantaged socioeconomic position.

In closing, I want to emphasize the need for research and demonstration projects targeting Latino gay and bisexual men. I strongly advise this commission to

examine and endorse the 12 recommendations made by the report titled "Hispanic Sexual Behavior: Implications for Research on HIV Prevention" which was recently released by the National Coalition of Hispanic Health and Human Services Organizations. Thank you.

DR. OSBORN: Thank you very much.

I am glad you could be with us.

DR. GREEN: Yes. Good morning. I am Richard Green. I am professor of psychiatry at the University of California, Los Angeles, and I am also an instructor in the School of Law at UCLA. I am going to talk about sex law and HIV.

I just finished a text on -- called Sexual Science and the Law for Harvard University Press; it runs about 300 pages. And I just finished a course at UCLA law school on sex, psychiatry, and law that runs 32 hours. So in the next eight or nine minutes, I will try to focus on a few topics that perhaps are salient here.

What I will address are two issues at the interface of sexual behavior and law that contribute to HIV spread: They are the impact of law on the cultural context of homosexuality and the impact of law on commercial sex. First, homosexual behavior and law: Multiple sexual partners fuel the epidemic of any sexually-transmitted disease. The term "promiscuity,"

value-laden and pejorative, conveys the societal attitude towards non-discriminating sexual contact. Male homosexuals have traditionally been indicted as the most promiscuous of sexual partners. In the pre-HIV era, a Kinsey Institute of Bell and Weinberg -- a '78 study -- found that 43 percent of gay men had had more than 500 sexual partners.

Nearly a quarter of a century ago, Martin Hoffman in his book The Gay World characterized this lifestyle of multiple, serial partnering in the gay world as the inevitable outcome of a social order that refuses to legitimize same-sex relationships. Today that inevitable outcome is a tragic consequence.

American social order works against consolidating a male-male relationship. It criminalizes the very conduct that defines the group. Nearly half the states continue to have sodomy laws against consenting, private, same-sex contact. American social order also permits civil discrimination against the group. Forty-six of 50 states allow discrimination in employment and housing on the basis of sexual orientation.

Criminalizing a pattern of sexuality that defines a basic component of identity and permitting discrimination in consequence of a basic component of identity has profound psychological consequences. Self-

image is tarnished. Self-worth is devalued. Guilt ensues from inwardly-directed hostility and internalization of societal scorn.

The consequences are personal devaluation and depression and conduct consistent with personal devaluation: self-destructive behavior. There are many ways to commit suicide. Research demonstrates that male homosexuals who have incorporated societal disapproval of their sexuality, who experience significant others as disapproving of their sexuality, and who experience more emotional conflict are more likely to engage in sexual behaviors that are self-destructive. Specifically, they are less likely to use condoms during either insertive or receptive anal sex.

Laws that discriminate against homosexual persons must be subjected to the strictest level of judicial scrutiny so that the equal-protection clause of the constitution provides protection comparable to that afforded racial and ethnic minorities. The court must recognize the fundamental nature of sexual privacy so that laws which criminalize consenting, private sexual conduct are invalidated. Federal laws that protect against employment and housing discrimination based on race or gender must be extended to sexual orientation.

Humans are programmed to bond. Marriage is one

of the few fundamental sexual rights protected by the Supreme Court -- the Ziblocky [phonetic] case, Skinner, etcetera. But marriage is defined as a status attainable only by one male with one female.

American social order forbids the legitimization of a same-sex relationship in the civil status sought by couples who wish to announce to the world that their relationship is monogamous or at least special. Same-sex couples cannot marry. Attempts by same-sex couples to marry have been frustrated by both state and federal courts.

An alternative to marriage that legitimizes same-sex couple relationship is domestic partnership. Two purposes are served here: Domestic partnership announces the significance of the relationship to the world and also provides civil advantages, long-denied to same-sex couples. Among others, these include sharing medical insurance benefits, hospital visits as a family member, apartment inheritance in rent-controlled buildings restricting lease transfer to surviving family members.

A few local jurisdictions have enacted domestic partnership law. Some have submitted the issue to referendum. Some new laws have been repealed. But local prejudice must not reign. Federal domestic partnership law must be enacted.

Commercial sexual behavior and the law: Sexually-transmitted diseases find a vector in commercial sex. Both male and female prostitutes are at issue. The previously-ignored male prostitute has emerged as a major concern. Rates of positive HIV status run as high as 50 percent in some communities among both male and female prostitutes.

Because of the differential rates of HIV infection among homosexual and heterosexual males, in most communities the chances of a male professional having contact with a HIV-infected customer are higher than for a female professional. Consequently, they fuel the spread within the homosexual community.

One in six American men have had contact with a female prostitute during the preceding five years. Thus female prostitutes who are HIV-infected are a vector for heterosexual transmission, not only to male customers, but to female partners of those customers, the non-married woman or spouse.

Prostitute contact for married men has been a traditional "safe outlet" for non-marital sex. Commercial sex poses less threat to the marriage relationship with it anonymous non-relational quality as opposed to having an affair.

In earlier years, bringing home a venereal

disease -- now called sexually-transmitted disease -- when the disease was syphilis or gonorrhea was a risk, but the consequences may well have been less than with HIV. Then the male would often be aware of the infection early, and might be treated and cured before exposing a marital partner or other partner.

Prostitution, male or female, is illegal in 49 states. In Nevada, where it is legally regulated as of 1991, no brothel prostitute had been reported to have tested positive for HIV. Placing commercial sex outside public-health regulation under the futile control of the criminal justice system has been abandoned by many Western nations. Some European studies demonstrate that when prostitution is regulated or at least decriminalized, rates of venereal disease decline.

The positive way to "police" the health status of prostitutes is through regulation and periodic health examination. After 5,000 years of flourishing, it is clear that irrespective of moral considerations regarding the formal exchange of money for sex, prostitution is not controllable by criminalization. In continuing to deny prostitution's vitality, the HIV health risk is fueled by placing commercial sex outside of the purview of the public health system.

Conclusion: These proposals may appear to be

radical suggestions, but this is a radical time. History's colossal scourge is upon us. Ignoring identifiable and changeable factors that hamper its containment will be paid with the currency of lives.

Laws must serve the public welfare. Here they are failing. When, through the stigmatization of a group experiencing devastation, the law contributes to the calamity, the law must change. When, through failing to mount a realistic approach to an identifiable source of transmission, the law contributes to the calamity, then the law must change.

DR. OSBORN: Thank you for a very powerful condensation of your thinking. We appreciate that.

MS. ALEXANDER: Good morning. My name is Priscilla Alexander. I work at the World Health Organization in Geneva in the Global Program on AIDS. I am with a department called Intervention Development and Support, and I work in the unit called High-Risk Behavior, and my specialty is prostitutes and clients.

Before I went to WHO -- by the way, all those are three-letter acronyms, and when you go and work at WHO, you almost go crazy trying to keep track of the three-letter acronyms. It is a little bit like the pentagon.

But in any case, before I worked at COYOTE -- I

mean, WHO -- I worked with COYOTE, a prostitute's rights organization in San Francisco for 15 or 16 years. I am not a prostitute, and I never had the courage or something to demand money in exchange for sex, and I am saying this because I don't want to get credit for something I haven't done. It is not because I don't want the stigma of being a prostitute. I would welcome carrying it and probably do carry it because of my work, but I don't want credit for experience that is not mine.

I hope that I am -- have been a good listener to the thousands of prostitutes I have known over the last 14 -- I don't know -- since 1976, and so I am speaking, I hope, representing at least a lot of their interests.

Prostitution is illegal in all 50 states. It is only legal in rural counties in Nevada, and then only under very restrictive conditions. It is legal in brothels. A typical regulation is that -- and these brothels are only for female prostitution. I think that although Joe Conforte talked about opening a male brothel, I don't think it actually happened.

Anyway, women typically have to work three-week shifts in a brothel, and then they have to leave the town where they have been working. They are not allowed to live in the town. They must stay in the brothel during their three-week tours of duty, and depending on the

county or the town, they may work 14-hour shifts, or they may have to be on call 24 hours a day for seven days a week for those three weeks.

They have a weekly gonorrhea check, a monthly syphilis and HIV check, for which they are expected to pay -- and it costs, I have heard from different sources, 100 to $150 a month. About 65 percent of the income goes to the house, some of it in direct commission, a lot of it in the high-inflated charges they have paying for laundry, clothes, cigarettes, whatever else that they want.

Some prostitutes have reported that there is a certain amount of drug use in the brothels and that they get drugs to keep them awake and drugs to help them go to sleep from the doctors who do the STD checks. There are some women who like to work in those brothels because they can earn a fairly high amount of money in that three-week period, and then they can go on to do something else.

There are women who work temporarily. There are women who work on a long-term basis, but it is not a system that most prostitutes would work in, and if that were the model for this country, the vast majority of prostitutes would continue to be clandestine, as they have always been whenever there is a regulated, registered system.

In the present day, examples of registration

systems exist in Athens where 350 women were registered in order not to be arrested, and there are about 3,000 working illegally. In Nevada, the figure is about 300 work in the brothels, and an estimated 3,000 work illegally; and since all of prostitution involves migration on a constant basis -- largely because of the laws -- any numbers that you have are only a tip of an iceberg.

In Senegal, a much-touted registration system has 8- to 900 women registered in Dakar. There are an estimated 16,000 prostitutes working in Dakar, so it is a joke for the most part. If you look at the history of registration and mandatory testing -- if you look at the Contagious Diseases Acts in England, they had no control of sexually-transmitted diseases. Hundreds, maybe thousands of women were rounded up, taken to locked wards in hospitals and forcibly examined with a brand-new instrument called a speculum, and STDs maintained their merry way.

The feminists who were fighting the Contagious Diseases Acts pointed out that the clients were often sailors who had been at sea for many months, may have been having sex with each other and infecting each other and then infecting the prostitutes. But as is always the case in history, it was only the female prostitutes who were

rounded up.

In France, they tried a regimentation system with the brothels, and that lasted until World War II. It also had little effect on STDs, which continued outside of the prostitutes, since most prostitutes worked clandestinely. I think the word "clandestine" means "prostitute," almost. It is most commonly used in that connection.

St. Louis tried a regimentation system in the 19th century, which didn't last very long, and of course, the Nevada system is a regimentation system, and even though people like Russ Reed [phonetic] say it is wonderful, it is not, and it really has little impact on anything except the psychological well-being of the women who work there.

The current system in the United States is prohibition. We know from the alcohol prohibition that it doesn't work, and many of us also think that the drug prohibition is an unmitigated disaster. Prostitution prohibition is also an unmitigated disaster. Sodomy laws are an unmitigated disaster.

It is not a rationale thing to prohibit voluntary behavior that gives pleasure. And some of the previous comments about the nature of pleasure and some of our confusion about pleasure -- it is really true. But if

people find something pleasurable, just like any rat in a maze or any other animal, we are going to seek that pleasure, and human society all too often tries to restrict it, and so prostitution is a good example of that, and I go into a lot of it in the paper.

We arrest between 100- and 125,000 people every year. About 70 percent of them are women. A far disproportionate number of the arrests are women of color. Clients are almost never arrested except in brief periods where there is a fanfare that they are ridding the city of prostitution, and so they are going to arrest the client.

Major crackdowns occur before public events like the Olympics or the Super Bowl or the Democratic National Convention, and I lived through the one in San Francisco, and I hear from my sources in New York that the roundups for this year's convention are already happening, and while women are normally arrested and fined and let out again, they are now being sentenced to six months in jail in order to protect the Democrats.

They appeared to do this less for the Republicans. It may be because street prostitution is not associated with Republicans. They go to the escort services, and so those organizations don't get arrested as much anyway.

But I also have noticed that baseball -- the

World Series does not seem to be preceded by major crackdowns. I don't know why football is more associated with crackdowns on prostitution than baseball, but the press never called before the World Series when I was at COYOTE, and they always called before the Super Bowl and wanted to know how many prostitutes were going to such-and-such a city, etcetera.

So it is an unmitigated disaster -- the laws. It is abusive. It has enormous impact on the social and emotional well-being of prostitutes. It has a very negative impact on their health. It makes it difficult for them to get health care. They do not want to be identified as prostitutes, because they are afraid that they will end up in jail.

If they are publicly identified, they can also lose custody of their children; they can be evicted from their housing. If they are foreign-born, they can be deported. If they have worked as a prostitute in another country and they try to come into this country, they can be stopped at the border. I have had calls from prostitutes who were denied the right to get on a plane in Canada that was going to land in the United States on its way to Asia, and it was only -- she only would have transit, in the transit lounge, and they wouldn't let her get on the plane in Canada because she had once been a

prostitute 20 years before.

There was also a case of a woman who was French, a French national working as a madam in a brothel in Nevada -- a legal brothel, a legal job -- and they instituted deportation proceedings against her, so that there is -- there are major consequences to being publicly identified as a prostitute. The stigma is very strong, exists everywhere in the world, and so the issue of registration is not really very practical, because prostitutes are going to avoid it because of the stigma, which has life-long consequences.

So what are the alternatives? Because the current system obviously doesn't work for anybody, except that it proves the arrest statistics for police departments who are so unsuccessful at finding burglars, murderers, and rapists, and so the prostitution arrests and the drug arrests make it look like they are doing something, when we know what they do: They beat up people like Rodney King.

There are a number of countries that have looked at alternatives who are currently looking at alternatives. Australia, The Netherlands, and Germany are probably -- the most active prostitutes' organizations, and therefore, the debate about the law is maybe the furthest along.

In Australia, every single state has funded a prostitutes' organization to do AIDS prevention, and the same is now true in New Zealand, and as a result of this, there has been very high-level discussion. There have been national commissions and state commissions to look at the laws and to look at alternatives.

The government is, at this point, still unwilling to give up the idea that they can identify every prostitute and monitor them, and they -- in the one place where they did have -- so far modified the law in Australia, they issued land-use permits in New South Wales to brothels, which had the effect of giving the rich pimps the right to own a brothel and kept women who worked in small collectives illegal; and it is a good example of the kind of dilemma that happens.

I attended a European prostitutes' meeting last October, and this kind of pattern is happening in a number of places. In Germany, where every city is required to have a zone where prostitution is legal, prostitutes have been organizing to get better working conditions in the brothels. Police have been prosecuting the brothels where they have better working conditions because they say the good working conditions encourage women to be prostitutes, and it is against the law to encourage a woman to be a prostitute. So it is another example of the kind of game

that prostitutes get caught up in.

In The Netherlands, the government was looking -- what they have is prostitution is legal in zones where they have windows, the famous windows -- which also exist in Belgium -- and they are little storefronts where it is mostly female prostitutes, not exclusively. They rent a storefront for an eight-hour shift, and they essentially set up their own working conditions within those windows; and it is not a bad system, but it is -- again, everything outside of that is illegal.

Now, The Netherlands, as it is with drugs, is relatively tolerant, and so brothels are tolerated and escort services are tolerated, and there is some street prostitution and there is some enforcement against them, but not nearly to the extent that there is in the United States; and recently they have been looking at revising the laws, and they got caught in this dilemma that the state wants to regulate, identify, test the prostitutes, and the prostitutes want good working conditions so that they will be healthy because they have good working conditions, which include provision of brothels: clean linen, running water -- in many countries, prostitutes don't have running water. It would include limits to the number of hours; include the right to turn down a client who is abusive or drunk or refuses to use a condom -- all

those kinds of things which have to be negotiated in a working situation.

And the laws as they currently exist in most of the world deny prostitutes, whether they are male or female, to right to engage in any kind of collective bargaining with their bosses, and all of this makes it difficult to do AIDS-prevention interventions, because you have to reach the prostitutes, and if -- in this country, if you go to a massage parlor and say, I want to come in and do an AIDS-prevention education session, they will say, Why? We don't do prostitution.

If you call an escort service and say, We would like to provide some information to the women who work for you, they will say, We don't do prostitution. It is a felony for them to do prostitution, and they can go to jail for three to five years in California and longer in some states, and so it becomes impossible to work on that level, and I think the only interventions that have been established in this country have been on the street.

Now, it is the street prostitutes who are the most at risk because of their drug use and the drug use of their partners, but still, it is important to reach prostitutes at all levels. It is also important to reach clients, and my work in WHO is getting governments to support the programs that work with clients, with

prostitutes, and with the owners and managers of sex-work businesses.

And when I started to come back here, I thought I can't even conceive of anybody focusing on clients in this country, because we pretend they don't exist; and the Kinsey figures were 15 percent were regular clients and 65 percent were at least once in their lives.

In Thailand, it is 91 percent are at least occasional clients -- of men -- and growing awareness all over the world is that You want to reach clients, you reach men, and projects are happening. But I can't even imagine it happening in this country because prostitution is so oppressed and repressed and suppressed, and so I think something really has to change, and one thing that might be possible is to set up some kind of commission on the national level and also commissions on state levels to evaluate the laws, and the commission should include prostitutes, clients, health specialists, and others who can come up with some kind of a system that does not penalize the prostitute and that deals with the issue of working conditions.

Registration of prostitutes will not work; it never has and it never will so long as there is a stigma. Good health care is important, and I have been working with people from the National Health Service in England

and have really come to see that there are -- it is possible to have good STD services for prostitutes. It is not in this country, and I think that a lot of things could change, but it has to be respecting them as workers and giving them the good services and safe working conditions are the only way to deal with AIDS in the context of sex work. Thank you.

DR. OSBORN: Thanks very much, and we thank all of you on behalf of the commission for very thoughtful and thought-provoking testimony. We have time now for interchange, which I am pleased about.

And Harlon, why don't you start us off?

MR. DALTON: Okay. Thanks.

By the way, Priscilla, back in 1976 I had the dubious distinction of contributing to the cleaning up of the streets for the Democratic convention. I had brought a lawsuit challenging -- they used to do disorderly-conduct statutes to sweep up prostitutes. That was struck down, and immediately the legislature passed a loitering statute just in time for the convention, so I know that what you say is absolutely true.

I have one question for the two on this end, and then another question for the other three. I guess I wanted to sharpen what seems to be a debate between Richard and Priscilla -- or at least a disagreement, and

maybe not. Richard, in your testimony you referred -- no. Richard, in Priscilla's testimony, she essentially said that registration just won't work, even in a system in which prostitution is no longer illegal, and I wanted you to speak to that.

Priscilla, in his testimony, Richard spoke of prostitutes as "vectors," and I noticed that you -- in, at least, your spoken testimony, you didn't respond to that characterization, but that is one of the difficulties in dealing with AIDS and HIV.

So if you two could speak to those issues.

DR. GREEN: Well, I will respond briefly. I think Priscilla's and my goals are the same. I think it is the means to achieving that goal, and Priscilla is more aware of the efforts, and apparently not with major successes, of the means of regulation. The goals are certainly to enable -- to empower prostitutes to destigmatize prostitution, the process of prostitution, whether it is the customer or the professional; and we agree that a major first step is the decriminalization of commercial sex.

Now, what the social and political context does at the next step is something that I think many people from many nations need to put their heads together to see what has been effective and what hasn't been, and why, and

try to learn from the past errors so that the means towards the destigmatization of the process and the prostitute could be affected so that the ultimate goal of better living and better health conditions would be met.

I think we agree on the goal, and we agree on the first step. It is the intermediate processes that need to be, in fact, better researched and explicated.

MS. ALEXANDER: About the vector, I forgot it. Prostitutes are not vectors; they are people. They are people who get infected, and sometimes they pass that infection on. In the United States, although a significant proportion of street prostitutes are infected in some cities, they are not effectively passing the infection on. I understand that some of that picture is changing around crack, although I am not sure that the trade of sex for crack is exactly prostitution. Certainly, the social life of many women in which they trade sex for dinner or men trade dinner for sex -- I am not sure which it is -- is not called prostitution, so not all trades are literally prostitution.

But it is a very serious things, and the early papers on AIDS did view prostitutes as vectors a good deal, and one of the first papers that has caused a lot of problem is one that came out of Nairobi in 1985 on STDs, that the title of it was "Prostitutes: A Reservoir of

Infection" by Plummer, et al, and I don't know who exactly was in that group at the time; and that particular group has continued to publish things that treat prostitutes as vectors and a number other -- Hazeltine testified before Congress about prostitutes as vectors, and -- I mean, very quickly states in this country began passing mandatory testing laws because of that: California having a particularly onerous one.

I mean, mosquitos are vectors, maybe. Everybody can protect themselves against STD and HIV. It is not very difficult. All you have to do is use a condom or avoid penetrative sex. I mean, it is a not a very difficult thing to have sex without becoming infected, and this concept of people as vectors -- I see the same thing in my office: Some people who were talking about the issue of men having sex with men, which is not homosexual identity in many countries.

What you were talking about -- the Latino community in the United States is true in tremendous measure in Latin America; it may also be true in Asia; it may be true in sub-Saharan Africa; it is certainly true in northern Africa and the Middle East. I mean, there are all sorts of issues around this issue of vectorism, and one of the things that some of the people at WHO talk about -- Well, we should deal with the issue of men who

have sex with men who are also having sex with women, so we are going to deal with bisexuality, but we don't have to deal with homosexuality, because then we don't have this conception of them as vectors.

And so you worry about the prostitute because she is going to give sex to the male client. You worry about the bisexual because he is going to give sex to the female partner, who might give the virus to an infant. The woman who is infected is -- you don't worry about her for herself; you worry about whether she is going to give it to her partner or whether she is going to give it to a fetus.

So we have a kind of fixation on this issue of vector, which maybe relates to the fact that we don't have good health care in this country, and we don't assume that health care is for people to be able to protect themselves.

MR. DALTON: Thank you. My question for the other three -- I am not quite sure how to put this, but in today's testimony -- and Carole and Jose, you were here.

I don't think you were here yesterday, Dr. Money.

But both yesterday and today, there has been, I think, quite an important emphasis on looking at sex as meaning: as Dr. Gagnon put it yesterday, "sex clothed in

culture," rather than simply naked bodies.

At the same time, today there has been a very strong message -- and I think a correct one -- that is important to hold up pleasure, that to ignore sex as pleasure is to ignore an important part of sex.

Dr. Money, you talked in terms of pro-sexualism. And I guess my question is how these two ideas, sex positivism or pro-sexualism and kind of sex as really having a lot of significant social and cultural meaning -- how they go together. Let me give you an example: Early on in this epidemic, one of the things that the gay community did best -- the organized gay community -- was to eroticize safe sex.

We don't hear much about that anymore, and I think in part because that effort, in practice, it resulted in things like comic books which showed people enjoying masturbation, and then those comic books could be held up in the US Senate and waved around, and we were back to looking at sex at naked bodies rather than in the context of what human beings do as part of their identity and whole self.

And so I guess the question is how do we talk about things like masturbation? How do we eroticize safe sex? How do we present sex in a positive light and at the same time, say to society, Sex isn't just about bodies

coupling -- or maybe not even coupling -- it is really something that is changeable? How do we talk about sex as being something that -- sex and sexuality is something that is changeable over time without inviting people -- local society to try to change people's sexual orientation, for example.

DR. MONEY: Shall I say something first? Well, your question, as you well know, is a very difficult one. That is why I said one needs a charismatic leadership so that somebody has to start making a proclamation, and it should be someone who carries a great deal of prestige, or a group of people who carry a great deal of prestige, so it simply proclaims that the idea of establishing a positive sex is itself a good idea.

Then I don't believe there is a confidence in any single one of us to be able to say what is a program of positive sex. This is the point at which I would want to gather data from various sources, both within our own society and culture and transculturally, and I have a couple of examples: One of them is that within our own society, one of the things that gay people did early in the epidemic was to establish "Jack and Joe" clubs -- "Jack" for jack off and "Joe" for jerk off, and people assembled together in clubs to play safe sex, and they would look at television -- at video programs, and they

would be usually naked themselves, and some of them would be masturbating themselves, and some of them would be masturbating in pairs.

Whatever they did, it was always regulated in terms of the membership rules that it had to be safe sex. So one actually has a piece of evidence at hand as to something that can be done.

I concentrated my remarks on young people, because the only thing that I pick up from the society in which I live is that we expect young people will not breathe, will not eat, will not maturate, will not defecate, and will not have sex, so to speak. But obviously, they are all in the same category and you cannot stop any of them by edict, so we have to face up to that, which is why we need this new leadership, and, as I said, this transformation of what is now heresy into the new orthodoxy.

The second example that I can pick up, again from our own society, is that especially in large cities -- and I expect New York City is the chief one of this -- the general public has already established its appreciation of erotic movies in the late-night blue movies on the television channels as another way of safe sex.

Now, the extent to which that has been

incorporated into safe-sex practices between couples and -- or between groups of people together -- I don't know, because nobody has ever recorded it, that I know of. But it certainly is yet another example of how the population is inventing methods of safe sex for itself during this dangerous period of the epidemic.

Cross-culturally, one undoubtedly could find some more evidence, and so piecemeal, one can build up a volume of evidence as to what has been working, what has been tried, and what may be still further tried and put to the test of reality.

DR. VANCE: Well, to respond to your first question, the examples we have -- certainly we know sexuality is changeable. When it changes is when people want it voluntarily to change. When others try to change it, it is extraordinarily resistant to change. We see that clearly in sex history.

Secondly, this -- the problem you are naming is a very serious one. I actually would put more of my faith in grassroots change, and like Dr. Money I see many examples of people making videos, looking at videos, exploring and inventing a whole range of different erotic materials. I can report from San Francisco that Jack-Off clubs have go coed to Jack-and-Jill-off clubs, if you want to know the latest about that.

So there is a proliferation on the grassroots level of all different kinds of things. I think the critical kind of point that has to change is what is being said publicly in policy discussions and political discussions. That is the place that pleasure is literally invisible, and I think that must change.

And you are saying, Well, why should it change when the specter of sex panic, you know, lurks around every corner. That is true. But I think sex -- the key to a sex panic working is that people are unable to mount a positive defensive sexuality; that is why it works. When this tidal wave of emotion and hysteria hits, people try to imagine the best defense, and they think it is to be found in the right to privacy or in the NEA controversy and the notable ballets the NEA has funded.

It is an attack that is being launched on sexual grounds, and it can only be answered by speaking about sexual pleasure as a legitimate right, and in fact, most of the population has experience with sexual pleasure, has some interest in it, and if they can be assured that there are responsible, safe, and healthy ways to have more of it, they will be interested.

MR. PARES-AVILA: The fact that eroticizing safer sex has worked in the Anglo gay community and it is not working for all Latino gay men is a fascinating

question that I constantly struggle with. Yesterday something was said that sex is not just a biological function; it has also psychological, social, and emotional meanings; and I think that when two people come to bed, they bring with them their histories, you know, their gender, their orientation, the race and social class, and when I think about, for instance, this small study that I did with Latino gay men who have fairly high contact with the Anglo gay community, I wonder about the question of power differentials and how they get played out in that diet.

I also wonder about why they do not respond to those messages, and I guess that the Latino culture is fairly conservative in terms of sexuality; and Dr. Vance was talking about the different functions of sex, you know, sex for procreation and sex for pleasure, and I think that those are very conflicting values that we are brought up on in our culture. That is why I think that there is so many Latino men who lead double lifestyles and marry to have children, but then they have -- they lead a secret lifestyle, and then there are other men who do not even identify at all as homosexuals but engage in homosexual behavior.

DR. MONEY: I have another comment to add: With regard to pleasure, I am not against pleasure at all,

but in fact, when talking about sex and the HIV transmission, one can talk perfectly good sense without having to evoke pleasure. Sex is a factuality as well as being a pleasure, and the evidence of that for a very large proportion of young boys reaching puberty into early adolescence is that they have wet dreams in which the entire drama is unfolded before them while they are asleep, so you don't even have to learn it, so to speak, or you don't have to be taught it. It is there; it is a part of us human beings.

For girls, there is not quite the same exact replication of the wet dream, but there is plenty of romantic and erotic daydreaming. So we are actually just simply trying to make sense out of something that belongs to us human beings, and to make sense of it in the best possible way, that we save our new generation of young people from killing themselves by getting the HIV virus.

Can we get pleasure as a by-product of it? Sure. But we still have to face it as a very basic thing about us human beings, irrespective of whether it is pleasurable or not, in exactly the same way as we have to face nutrition.

MR. PARES-AVILA: There is something else that I want to add, and it is something that I have experienced in doing trainings of outreach workers and HIV educators.

When we do these exercises on sexuality to make people feel at ease with sexuality and their own sexuality to be good HIV workers, often people do this exercise about recalling their very first sexual experience, and that exercise has been proven to be disastrous; and I say that because we should know that one in three women and one in ten men in this country have histories of sexual abuse as children, and I think that researchers and clinicians need to look into the connection of early sexual trauma when it comes to HIV prevention.

DR. OSBORN: Yes, Eunice.

MS. DIAZ: Yes. Right along that line, Jose, I just wanted to ask you: I know you have done work among the various Hispanic subgroups. Did your work or that of other investigators you have worked with find any salient differences between, let's say, Mexican-Americans or Mexicans and Puerto Ricans which are so affected by HIV epidemic that would be significant to our deliberations?

MR. PARES-AVILA: Well, there is more empirical data and more literature available on Mexican men, and this comes mainly from anthropological studies that have been conducted in Mexico and then some ethnographic work that has been done in California with Mexican men.

In terms of data on Puerto Rican men, there is mostly data from the focus groups from the Northeast

Hispanic AIDS Consortium and also the focus groups that I have done for the Latino health network and the psycho-educational groups. My sense is from -- mostly from clinical experience and just from talking to people is that -- and that is one point that I made, that it is very important and critical to look at Latino gay men as a diverse group in which men of Mexican or Central American origin may be very different -- their sexual behavior -- when we compare them to men of Caribbean origin from Puerto Rico, the Dominican Republic and Cuba.

Why that is the case, I don't know. I can speculate that acculturation plays a big role, and what the research is saying about Mexican men is that they -- Mexican men who engage in homosexual behavior -- their sexuality mirrors a lot of heterosexual norms, and they stick more to gender-defined roles, in which one partner always plays a passive role, and the other partner always plays the active role.

What I am seeing with men of Caribbean origin is that there is more plasticity in their -- in the way they see themselves as sexual beings, and there is more of an interchange in terms of being active and passive partners.

DR. OSBORN: Thank you.

MR. ALLEN: I have a question for all of you.

You mentioned about the abuse and sex and the potential connection with anger that type of acting out and so forth, if you all could comment to that.

But first, I had a question for you, Jose. In your testimony, you were talking about the isolation of individuals that are Latino and are gay: They don't fit anywhere rather freely, and yesterday Vickie Mays -- I believe you were here; you heard her testimony about that collective type of educational process of being a part of community, a part of larger meaning and so forth, and the totality of one's being being a part of that sexual identity and so forth.

My question is how do you -- is it that the information is not being reached by the gay Latino or a person that doesn't really fit into the cultural norm and all of that, or is it that the information that is received is not easily translated and assimilated into the individual's makeup simply because there isn't that connectiveness?

MR. PARES-AVILA: I -- my thoughts on that is, I guess, it is basically who is delivering the message. They -- I think that a lot of the Latino men do not identify with the messages that are being sent in the gay community in terms of AIDS prevention, and they don't see that as an issue that affects them.

And you are right. It is the constant struggle for men -- for minority men who are -- have to deal with the fact of being a double minority in this country.

MR. ALLEN: So what you are saying, at least if I translate it into -- that the -- it is not the content; it is how the message is -- it is who is giving the message out.

MR. PARES-AVILA: Uh-huh.

MR. ALLEN: So that --

MR. PARES-AVILA: Yes.

MR. ALLEN: So do we, in this country, have the energy to do it correctly?

MR. PARES-AVILA: Well, I think that it is do-able. This study that I did for the Latino Health Network involved not only research, but intervention. And what we did is that we did outreach to recruit them in, and we have them agree to do the survey and also to participate in three psycho-educational sessions.

The way we designed the session was using Powlafraydes [phonetic] methodology. And we didn't start the sessions by telling them, We are here to talk about AIDS and how to protect you about AIDS -- from AIDS.

We spent the first two or three hours talking about what does it mean to Latino and what does it mean to be gay in this country and how does that affect your

esteem, your relationships with other people, families, friends.

And, after processing that, we move into issues of HIV. And what we saw, as a result of that process, is that people really engaged in self-examination. We made them aware, without us imposing on them, what they needed to know to protect themselves from HIV.

And we saw true empowerment happening, because after the third session, these men say, We want to continue meeting. And, as a result of this little project now, there is a political organization of Latino gay men in Boston that came about this. And they are working actively now on issues of HIV and Latino gay issues.

DR. ALLEN: This is a general question for any of you who may want to respond. As we have listened for the last day and a half -- or, yesterday afternoon and this morning -- it is very obvious that the panels tend to have one perspective on this.

We have not heard from the religious right. We have not heard from the very conservative political side, from those who use the catch phrase, quote, family values to mean whatever restrictive sense they may want to mean by it.

And I think to me -- the question I am wrestling with is that there is a real dichotomy here in

our country. We have 250 million people. We represent a wide range.

And yet, what gets put into law, what gets put into acceptable educational programs, what can be funded without protest by government, you know, tends to all go in the more conservative direction.

How does one go about -- what steps, what recommendations do you have in terms of how we build, over the next several years, a different approach or can bring a little leavening into what we, as a country, we as a society do.

And I recognize that we are multi-pictorial, that it can't be a single effort, but it seems to me that we need to look at steps that might be taken specifically. And I just wonder what you might have in the way of recommendations.

MS. ALEXANDER: I think a lot about this in Geneva, as a read the International Herald Tribune every day.

I think that the very conservative strand in this country represents, from what I can gather, 15 percent of the population. And that 15 percent is strangling the country.

It is an interesting dilemma, and I think a lot of it has to be an issue of the courage of politicians,

who have to stop pandering to the right wing sentiment. And they have to take a risk and start -- I mean, watching the presidential primary system from Europe has been bizarre, because all you get in the press there is standings in the polls, and nothing about what anybody thinks or what they believe.

So I think that there is a crisis in this country, if the press coverage is any indication, in that we have let public opinion polls take over the thought process. And it is obviously going to crash, if they don't change.

I mean, they have to get back to -- politicians have to decide what they believe, and they have to fight for that and win or lose on the basis of their believes, not on the basis of whether they can figure out what the public opinion polls are telling them.

And I -- it is just going to have to -- the people on the liberal side are going to have to say, We are not going to let this frighten us any more, and we are going to move ahead and try to make the changes that we think have to be made.

And start educating on some level, instead of always looking behind their back and trying to figure out what is going to get them elected.

It seems to me there are a tremendous number of

crisis issues in this country right now. And the rioting in Los Angeles has just made us begin to look at some of that again, but those wounds have been there for a long time.

In terms of prostitution, it is interesting. It is not really exactly the same liberal/conservative split. In England right now, the Mothers Union, which is the Anglican women's organization, is proposing a brothel system. And the nurses' association is also considering it. And that is not coming from prostitutes or liberals. It is coming from fairly conservatives.

Now, again, it is the regimentation system. Let's line up the prostitutes and test them, and then they will be clean, and our husbands will go to the prostitutes, they will come home and they won't give us an STD, which is where that is coming from.

But, even so, the fact that that is coming out of the conservatives means there is some room for discussion.

DR. GREEN: I will comment on it. I am sorry. What?

DR OSBORN: Dr. Vance?

DR. VANCE: I think in a democratic society, it is very helpful to continue to stress the idea of diversity. This is a society in which there are

circulating now many different sexual standards: a procreative one, a consensual one, a pleasure ethic. There are many different sexual subcultures and sexual values.

I think public policy, in promoting health, has to recognize all those different values, all those different populations, and provide service and information for them all.

What we have, in fact, now is the view of one segment which is being promoted as the view of all, which it is not.

MR. PARES-AVILA: I just want to add a little bit to that. I think that the underlying message, in terms of going back to traditional family values, is sticking to melting pot ideals in this society. And I don't think that things are going to change much until we admit that this is a multi-cultural society.

DR. GREEN: Yes. I was reminded of an event that took place in the psychiatry community -- the American psychiatric community about -- now it is 19 years ago -- which reflects on the issue that I discussed of the public perceptions of homosexuality.

Up until 1973, homosexuality was categorically a mental disease, I think, in psychiatry. And it appeared that the vast majority of the psychiatric community agreed

with that designation.

And very gradually there began to appear a body of research questioning it. There began to be a very, very outspoken minority, both within the psychiatric community and by the consumers, the homosexual community, challenging the politics, challenging the research findings.

And it became increasingly clear that the status quo wasn't working for many reasons, both in terms of mental health and in terms of politics and discrimination.

And ultimately the ground swell became an important movement within psychiatry. And at the time, the professional leaders of nomenclature and research committees declared that homosexuality was no longer going to be designated categorically a mental disorder.

At which point there was something of an uprising in the professional community and psychiatry, demonstrating as an extremely democratic profession, submitted the question to referendum, which made a lot of us, who are on the reform side, nervous.

But one of the things that saved the day was that all three candidates for the presidency of the American Psychiatric Association endorsed the delisting of homosexuality and restricted their politicizing to other

issues at the time.

And so the referendum to put homosexuality back in the list of disorders failed. And even though it is not -- it is still, almost 20 years later, not a unanimous view by American psychiatry.

The public perception and the political and mental health impact of that process has been profound, and perhaps there is something to be learned in that.

DR. MONEY: I used the word sexosophy, because it has been a very useful word to me. The sexosophy of the ultra conservative people has no foundation on which to base itself other than its own sexosophy.

But the sexosophy of the ultra liberal people also has no foundation on which to base itself other than its own sexosophy. And so we have people just fighting with each other.

It is like political parties fighting or nations fighting. You accept your own axioms, and then you go from then on.

So one of the things that I have considered my possible contribution to this dilemma is to write the history of how we got to be the way we are, because sometimes to understand the history is to make it look as absurd as it often is.

And to understand that the anti-sexualism of

the last two centuries was in fact an inchoate attempt to answer the problem of the epidemic spread of syphilis and gonorrhoea was a great enlightenment to me.

And to understand that people behave in utterly an irrational manner when there is a plague that they don't know how to control is part of that enlightenment.

In the 1300s when the Great Plague, the Black Plague hit the earth, there was the utmost in irrationality in response, including cementing up Jews in their houses as being the cause of it, because they were not Christians, and then either starving them to death or burning them to death, and so on.

And, I might add, in this very current period in which there is such a stress about AIDS, there has been a totally irrational eruption of ideas about the extraordinary widespreadness of sexual abuse in childhood.

Now, I have worked with sexual abuse for years, and I am not saying it doesn't exist. The exaggeration of it, the hysteria about it and the false accusations of it are a part of the irrationality of the times.

And the extreme of that irrationality is to say that all of these people who are abusers and the causes of everything that is going wrong with sex, the disillusion of the family, and on and on the litany goes, are devil worshipers and members of Satanic cults, which is -- there

is simply not evidence for it.

Well, so much then for understanding the history of how things happen. I have, perhaps a naive, trust that understanding the history may help to bring about some change in the attitudes on a widespread public scale.

The second point I would like to make is that the sexosophy we live in at the present time is one which creates a catch-22 for everybody with regard to sex. You are damned if you do and damned if you don't, which applies not only to prostitutes, but to all of us.

And one of the very serious problems about genuine sexual abuse of children is that they do not come and tell you about it. And it doesn't have to be sexual abuse. It can be any kind of violent abuse and terrible problems of isolation and locking children up in cellars, and so on.

They come into the hospital and they lie to you about what their parents to do them, even if you have substantiating evidence from the other side, because that is part of the nature of human nature when you are in such terrible distress.

When you are in a catch-22, it means that you are damned if you admit it and you are damned if you don't admit it.

And so even simple things like plain, ordinary, normal sexual games in childhood and becoming normal, like all primates do, places children in the position where they don't dare tell their children or their school teachers that they did it, because they are damned if they did it and they are damned if they didn't do it. They are damned if they tell it and they are damned if they don't tell it.

So you go up the ladder -- the age ladder and you find throughout everything that has got to do with sex in our society, everybody gets caught in this catch-22, and therefore, they can't come forward and tell you.

I can't come forward and preach on television on Sunday mornings the message of heresy that I gave today, because I would be damned if I do it, and I am also damned if I don't do it.

Another example, the type that I see very often. I have written about love maps -- the development of love maps in children. They are not stuck in your head the day you are born, any more than your native language is.

And whether they get to be normal or pathological is pretty much a matter of chance and good luck. So let's take the case of the boy that you have all read about in newspapers often enough, who is the model of

perfection in society, who is the highest achiever in high school, who is a very active boy in the church group that he belongs to, and he is the one who kills the two girls next door by strangulating them while he is masturbating, and nobody understands why.

Now, why did he not come to me or Dr. Green or any of us here and say, I have this problem; can somebody help me with it before it is too late? Because he would be damned if he came to you and he is also damned if he doesn't.

This is why I say we have to absolutely turn our sexual values upside down so that people at last can come and tell us about themselves. So that they can come and tell us if they are running risks about getting AIDS. So that we can talk to them about the risks. And so that it is a matter of discourse in the public domain and not a breaking rule.

It is a big order. I wish I knew all the answers to your question.

DR OSBORN: Very powerful start. Thank you.

Scott, you had a question earlier that kind of got cut off.

MR. ALLEN: It was more of how we deal with the element of anger and whether it is done by the history of an individual with sexual abuse, or whether it is done by

the existential questions that arise when someone finds out they are terminally ill, or what happens in that sense of meaninglessness, sense of despair, sense of hopelessness.

And what we are talking about is HIV and sexual behavior and how we are dealing with individuals and that sensitivity of walking into someone's life and moving into behavior modification.

And the question I have is that we talked about this pleasure, but there is also the potential for acting out this anger element and the lack of regard for oneself or one's partner that I would like someone to discuss in some brevity.

I am sure there is a need to move on, but that is a concern, and it is not just pleasure as we are looking at the sexual act in some individuals that have not reconciled in living out that totality of life.

And so in that fragmentation of individuals that are moving in that, I wanted to know what are your potential intervention strategies in that regard. How do you reach someone that is in this rage element, which I have seen in some individuals?

And not necessarily just HIV. I mean, I don't want to stereotype saying someone finds out they are HIV positive all of a sudden explodes into this individual

that is acting out everywhere.

But even regardless of HIV status, that element certainly plays a role in our culture, and I haven't heard anyone speak of that.

MR. PARES-AVILA: I want to respond to that. I think that at a theoretical level a lot of people think about that.

When someone finds out about his or her HIV status, we assume that they are going to be very -- that part of their response is going to be anger. And that anger may be acted out in inappropriate ways, like saying, If somebody gave this to me, I am going to go out and give it to the rest of the world.

And that assumption has been used to speculate about how to regulate the behavior of HIV positive individuals.

And, you know, in the mental health field people have to talk about whether TARESOFF [phonetic] applies to someone who tells us in our office that, I am going to go out and infect my partner, and we have to inform that partner.

I think that the more regulated it gets, the less chance we have as clinicians to process the anger within. And in terms of my clinical experience, I have not seen one person acting out anger inappropriately.

MR. ALLEN: Let me clarify. What I am saying here is not on that cultural level of how do we stop this as a culture. How do we interact with individuals?

And I wanted to stress I am minimizing the fact of HIV positivity being an ingredient, because I am just talking about our cultural dynamics. I am not talking about a person coming -- because that is stereotyped and that is true. It is very minimal in this epidemic, and it needs to be stressed.

But the element of how one acts sexually and having this kind of emotional baggage that we carry -- all of us carry, whether it is HIV or not, is the question that I have.

As we are talking about pleasure, we are also talking about the other dynamics. And one of the concerns I have is how we minimize the need for on-going counseling with individuals. That is kind of last on the list of funding, and so forth, but how do you interact with individuals.

And I do want to step away from that, because that was the first thing you heard was, okay, we are talking about -- how do we stop this behavior of someone that may go out and infect.

In other words, how do we live in that -- as we talked about the wholeness yesterday of the sexual being.

It is all the emotions and how we --

MR. DALTON: Actually, I was going to ask Carole if maybe she could take a crack at this question, because she has written a lot about -- in fact there is a book entitled, Pleasure and Danger, which recognizes that sexuality, as an individual matter and a cultural matter, has both of those potentials for us.

And part of what we will be doing dealing with sexuality is to somehow try to acknowledge both of those, and so --

MR. ALLEN: Harlon is the only one that understands. Thank you, Harlon. Harlon always does this for me.

DR. VANCE: Well, I think you are right that sexuality is coded as both a source of danger and a source of pleasure.

What I was trying to say is in our public discussion, I think it is much easier to recognize and go on about all the different sources of danger than it is in formulating policy to also talk about pleasure. Okay?

However, I would also say that, although since the Victorian Age, sexual danger, ranging from VD to pregnancy to sin to damnation to any number of things, you know, symbolically has been elaborated.

There are other sources of sexual danger that

are quite physical and real and material that it is quite possibly to do something socially and culturally about, like continuing to emphasize the idea that sexual behavior should be consensual.

Strengthening education, social service and prosecution for sexual behavior, including sexual harassment, which is not.

Giving people, particularly women, resources to escape from situations that are exploitative in which they are relatively powerless in which sex is confused with domination.

And I think more broadly doing what is called cultural education in schools to make clear there is a difference between sexuality and domination.

MR. ALLEN: And that is the point of the oppression -- an example, the oppression of women and the idea of the dominance issue. That is kind of what I am getting at.

I mean, when you say consensual, sometimes that is not and sometimes it is and the fine line there, and so this --

DR. MONEY: My --

DR OSBORN: Let me get a couple of very brief comments, because we are actually out of time.

DR. MONEY: Well, my response to your question

is that it is really addressing two issues. One is sex and sexuality, eroticism. The second one is violence. And both of them are liable to be catch-22s in our society.

In fact, there are some people who talk about a pornography of violence as there is a pornography of sex. And sometimes the two of them meet together and they do in sadomasochism.

And the most extreme examples of the forms of paraphilia or kinky sex or in the perversion of the meeting of eroticism and violence are lust/murder.

And, therefore, really what you are addressing in the ultimate analysis -- what you are questioning is how does one deal with the extremes of violence and how does one deal with the merging of violence and sex.

MR. ALLEN: More with the subtlety of violence.

DR. MONEY: Well, it can be subtle --

MR. ALLEN: Right.

DR. MONEY: -- but it can also be very, very right out in the open. But it is -- by my reckoning, it is particularly and majorily a problem of pathology that one has to disentangle here.

One of the things that turns up time and again in cases of lust/murder and serial murder that I have been aware of is that the person has a history of having been

subject to capricious violence.

And so what one is in fact seeing is the post-traumatic stress syndrome at a long delay before it appears.

So, in brief, I think that your question is opening up the whole issue of sexual and violence in psychopathology. That is the way we should really to try approach it.

Maybe I could conclude this comment by saying one serial sex murderer, in particular that I interviewed and got a lot of information from, was so puzzled and non-pulsed by his inability to explain his own behavior that he wanted to volunteer to be used for brain experimentation to be executed instead of just to be, as he said, barbecued in the electric chair, because he like to leave -- have left some legacy as to why it is that he did what he did and perhaps be of benefit to the next generation.

MS. ALEXANDER: I think that the issue of violence, which certainly is fairly extreme in this country, and sexual violence in particular, is heavily related to the repression of sexuality in this country.

And the discussions that we have had here about the need to bring pleasure into the open and to talk about sex as a positive part of life --

I mean, I have often thought that the reason rape is such a serious problem in this country often has to do with our heavy repression of sexuality and so sex becomes a weapon, and it is a way of acting out anger about other things.

We have serious problems about emotional vulnerability and intimacy and violence comes out of that.

I also wanted to say something about the issue of consent. And I prefer the term mutually voluntary behavior, because consent implies that somebody is asking and somebody else is agreeing to do what the first person has asked.

And, although -- and in all relationships there is a give and take around initiation and agreement. When we are talking about sexuality, we want something to be mutually voluntary that both people are able to make a conscious decision, or however many people are involved, a conscious decision to do that which they are agreeing to do.

We really have -- we also have this culture in which women are not supposed to have sex and men are supposed to have sex. And even though the much vaunted sexual revolution of the '60s supposedly began to change that, it really still exits.

And women are supposed to be virgins and men

are supposed to be sexually experienced. And that dichotomy sets ups a kind of scarcity that violence is then used to overcome.

And the way prostitution is carried out in a society has a lot to do with this idea that women are supposed to not be sexual and men are supposed to be sexual. And we have enormous consequences.

DR OSBORN: We are running substantially -- a little bit more than I had hoped over our time right now. And I know people will start getting jumpy about airplanes if we run too late, so let me thank you all very, very much and hope that additional conversation can carry on informally afterwards. And we appreciate your comments this morning.

We will take a 15-minute break and then return for additional comments.

(Whereupon, a brief recess was taken.)

DR OSBORN: We have our next group of panelists. And I will, again, welcome you collectively and ask, if you don't mind, if you will introduce yourself.

I will mention that Dr. Selverstone has replaced somebody who was on the program before. We are very happy to have you here. And, Tim, we are very pleased that you are with us And so those will be slight

changes in the way it is depicted.

But, if you will, as you go introduce yourselves and speak in order -- maintaining enough brevity so we have a good chance to interact with you, we would appreciate it.

And Dr. Shervington, why don't you go ahead.

DR. SHERVINGTON: I am Walter Shervington. I a psychiatrist. I am a professor at LSU presently on leave of absence, and I am the Assistant Secretary for the Office of Mental Health designee for the State of Louisiana.

In opening, I just have to make one comment that doesn't have to do with my presentation. The audience has gotten a bit larger at this juncture. This morning it was a bit scarce.

I am on the guidelines panel for the agency for health care policy and research, and we have had two open forums. And it is troublesome that these very, very important episodes are so poorly attended.

And I just had to comment on that, because the same thing happens to us. I hope this doesn't happen to you every place, even with the best of work, in terms of publicizing the occasion.

I would like to begin my remarks by first thanking the National Commission on AIDS for allowing me

the opportunity to give this presentation.

I also want to preface my remarks by making clear that I am not speaking to this commission as an official of the State of Louisiana in my capacity as Assistant Secretary designee for the Office of Mental Health, nor am I speaking in my role as a member of the HIV Guidelines Panel of the Agency for Healthcare Policy and Research.

You have to get those things out of the way first. So these remarks are my own thoughts, feelings and observations as a result of my work in this area as a psychiatrist.

My loss of many close friends to this disease, including a play son, who was an outstanding human being and an excellent lawyer, and my experiences as a black male person trained and treated in order to be, hopefully, a keen observer of the dynamics of self and other human beings as we struggle to survive and contribute in this existence.

First, some general remarks. The Commission is surely aware of the severe conservative climate under which we all struggle and which promises to relegate our society with all of its resources to little more than a mediocre group of people warring amongst ourselves with the almighty dollar as our god.

The politics of race of the last 13 years, the recent riots in Los Angeles, the decay of our cities, the open support of the greater arming of Americans, the dissolution of the family unit at all levels of society, the us versus them mentality, and what appears to be a commitment to racism so strong that anyone who lived through and participated in the civil rights movement must live in disbelieve that so much pain was experienced and so many lives lost to be here 20-plus years later are but a few examples of our conservative largess.

Certainly not a climate which offers much hope to a troubled adolescent population which must face inhalation or annihilation as relates to sexual expression, something no other living generation has faced since the discovery of penicillin and a treatment for syphilis.

That is with the exception of the men of the Tuskegee study, themselves victims of the same racism earlier referred to and clearly not to be forgotten in today's halls of science.

Today's halls of science, which allows the nation's leading official psychiatrists to suggest publicly that males in the inner cities behave much like monkeys in the wild, as relates to their hyperaggressive and hypersexual behavior, and remain in high office. This

in the name of science.

"Troubled adolescent population" not as a comment on the relative pathology of today's adolescents, but to comment on the multiplicity of pits adolescents must traverse today and thus the attendant troubles.

Troubled perhaps, also, in a clinical sense as we observe contradictions, polarizations and ambiguity in our society as never before, conditions in which adolescents must struggle to develop a sense of self.

Like so much else in our society which we deem disposable, we have developed a large segment of our children which many of us refer to as, "throw-away children" because of the seeming ease with which we cease caring for them.

These children reside in all parts of our society, contrary to the popular view that they are only the children of uncaring, drug-taking, criminal, inner-city parents so absorbed in their own depraved pursuits they severely neglect their children.

No doubt there are plenty such parents; however, throw-away children can easily be found in the suburbs for many of the same reasons and more.

We speak a good game when it comes to the importance of children in our communities, but we don't live up to our rhetoric.

Adolescents at risk -- all sexually and chemically active children and adolescents. The Commission is well aware of the risk to children who are sexually active and/or actively use alcohol and other chemicals.

However, within this group, I think it is important to pay particular attention to the subgroups of these adolescents who are homeless, or for other reasons, live on their own and/or on the streets.

It is no surprise that most such children survive in one way or another through sex, and chemicals are often a means of getting rid of all the pain of such survival and what came before.

These adolescents often do not feel that they have a choice about their behaviors and in many ways do not. Many have already been the victims of sexual, physical abuse within our own families -- within their own families and elsewhere, and must carry this weight as well.

Almost all of these adolescents have histories of longstanding and significant traumas such that the specter of HIV disease is only one more life-threatening issue, and in some cases may be even a way out.

Adolescents in custody. Our state systems are seeing record numbers of young children you are actively

suicidal and homicidal, not to mention those who are adolescent.

Many of these children suffer conduct disorder and attention deficit disorder with few resources for treatment, predicting many more children for the streets when existing resources cannot provide services.

The existing resources include treatment facilities minimally and foster care and/or correctional custody maximally.

We have no idea of the numbers of children presently in custody in either system who are already infected with the HIV virus and certainly few managing any such system want to know, because of the problems such knowledge will create.

However, these are children at great risk, because of all of the things that can happen to a child in custody, not only at the hands of adults, but by other children and/or what a particular child may seek for a host of reasons while in such custody.

Children of poverty. Children of poverty of all races face many of the same problems: crowding, frequently dangerous housing, poor nutrition, violence, poor educational opportunity and all the ills with which we are so familiar.

However, there are some dangers that are more

prevalent in poor Black and Hispanic communities, not quite as prevalent in poor White communities.

The likelihood of early custody, imprisonment is highest for poor Black and Hispanic males, especially in inner city communities. Several factors now begin to operate all, in one way or another, related to potential sexual behavior.

It has always been my observation that crowding contributes to an increased likelihood of early sexual behavior, but heterosexual and homosexual. Be clear that these are behaviors and not necessarily lifestyles.

When several adolescents share the same sleeping quarters or with older persons, the probabilities for sexual expression between these parties increase the likelihood that the behavior, except in very traumatic circumstances, will be experienced as pleasurable is high.

Adolescent sexual experimentation is certainly generally experienced as pleasurable, as most of us can probably attest.

For the adolescent female, the circumstances leading on to further sexual exploration and/or activity, regardless of HIV disease, are enormous.

The same is true for the adolescent males; however, because of the increased risk of incarceration for the Black and Hispanic males, those, who may not have

had a homo-erotic experience in the situation of crowding, will have multiple other opportunities while incarcerated.

Again, this does not necessarily represent lifestyle, nor is such experience universal for all incarcerated males. The probability of pleasurable homosexual experience increases with the increasing frequency of an all-male living environment in or out of institutions.

As a result of these phenomenon, there are many more males in the community who are likely to have been involved in homosexual experience for a number of different reasons and who are likely to continue to behave bisexually, if not homosexually, in the general population.

A recent new story on one of our local TV stations pointed to the significant increase in the incidence of HIV disease within the local projects because of the importance of the macho male image for many adolescents in the community.

This has contributed to a very negative attitude toward condom use and an importance of having multiple partners in order to demonstrate one's prowess.

Homosexual adolescent males. Gay/bisexual male adolescents are still the group at greatest risk for HIV

disease.

These adolescents continue to face all of the difficulties attendant with this way of being, and in addition, must today confront being gay/bisexual with the omnipresence of HIV.

To be noted is the reappearance of fuck bars across the country, the reemergence of sexual tea rooms at highway rest stops and many of the other pre-existing familiar places where men were known to enjoy sex.

A recent local news story interviewing bisexual men in a long-established previous park location is once again being frequented in New Orleans for anonymous sex.

Adolescent males are much less able to feel sufficiently self-empowered to always broker successfully their own sexual safety.

This is especially true in a climate that gives no clear, consistent message to this population about the importance of condom usage, much less comfort about their sexual orientation.

I hear too often the resignation of the inevitability of HIV if one is male and gay or bisexual. This too was recently reported by young, Black gay males in Washington, D.C. when being interviewed about the alarming increase and prevalence in the D.C. Black community.

For Black and Hispanic gay/bisexual adolescent males, this illness, with its perceived inevitability and implied plague status, represents yet one more impediment to self-esteem placing this subgroup at even greater risk of infection and for acting out behaviors.

More lethal still is the combination of unprotected sex and substance use in the gay/bisexual adolescent community for all the reasons we all know well.

It is not my expectation that the National Commission on AIDS is empowered to correct all the ills of our society which I have mentioned here.

Perhaps this is even the wrong form for the presentation of many of our social problems; however, it appears to me that the psychosocial/mental health issues related to this disease are perhaps the most important issues on which to focus if we are to do anything about controlling the spread of this disease.

These issues are complex and difficult to talk about, being so charged around the issues of race, sex and substance use. Charged also because we must confront issues we would much prefer to sweep out of our consciousness.

How will you, as commissioners, speak to the underlying racism intimately apart of any resolution for change?

How will you, as commissioners, urge the investigation of the most intimate of sexual behaviors in order to stem the spread of HIV disease?

How will you, as commissioners, insist on providing hardcore HIV prevention techniques to all children, especially incarcerated children when the custodians insist such is not necessary?

You have, indeed, an enormous task, and I am willing to work on these very difficult issues with you, if you so desire. Many of us in this room are here to be of assistance.

Most importantly, many who have this disease or who are at great risk want to help. This death trap needs all of our collective help.

Thank you very much for allowing me the opportunity to speak to you today.

DR OSBORN: Thank you very much, Dr. Shervington. Very important statement. We appreciate your -- both your offer of help, which is very generous, and your being with us.

Dr. Selverstone.

DR. SELVERSTONE: I am touched by the previous presentation, and that is a tough presentation to follow. I appreciate the opportunity to address you. I am here in the shoes of Debra Haffner, who had a medical emergency

yesterday and asked if, indeed, I would come down and speak with you.

Debra is the Executive Director of SIECUS, the Sex Information and Education Council of the United States. I will assure you that she is physical well at this point, but unable to travel just yet.

And I urge you to attend, as carefully as you might, her thoughtful -- what I believe to be her thoughtful and challenging observations in the paper that I believe she has already provided you with.

My name is Bob Selverstone. I have spent more than 30 years as a teacher and counselor in the public secondary schools in New York and Connecticut. I have spent the last 15 years as a practicing sex educator in a high school in Connecticut.

During that time, I have also been a psychologist in private practice with adolescents, with adults and with couples.

For the last decade, I have been a board member of SIECUS and most recently president of the board of directors, and for the last week I have been the person who was featured in last Wednesday and Thursday's production of Children's Television Workshop, which was on PBS stations around the country, what kids want to know about sex and growing up.

Oh, wonderful. I like -- I am happy to hear that.

I have no desire to minimize or even attempt to duplicate what Dr. Shervington said, but what I would like to do is to focus on my area of, quote, unquote, expertise, which would be that of primary prevention.

And it seems to me that the world in general and the world of sexuality might be conceptualized as a jungle with some rare and beautiful tropical birds and flowers and fruits, but also full of alligators and pythons.

Nobody that I have yet heard suggests that we abandon our children without any information. Some people say don't go out there at all. Stay at home and never venture into the jungle. And indeed the Amish and some cloistered folks have survived in that manner.

For all the rest, I think we are saying go into the world, but. And I think the question about sexuality is not whether to do sexuality education, but how to do it, when, where and by whom should it be done.

One alternative, which indeed we have practiced up to this point, has been to abdicate that to others: to television, to videos, to ads, to peers. I am instructed -- even in the New York Times magazine section decides to now forego the subtlety and to say about the

very high priced automobile, It is not a car. It is an aphrodisiac.

The reality is sex education takes place all the time, not with our young people, but with our adults.

People -- thoughtful people differ about what we should do. Children's Television Workshop did an exhaustive amount of research before putting on the program. And part of the result of that was the following:

In some parents, in general, report, one, I may wish to slow down the process of my child's becoming an adult, but, two, there are bigger forces at work. And I acknowledge or accept the reality that my kid, and kids in general, are growing up faster.

Therefore, three, I am lying to myself if I pretend that my kids are not getting information elsewhere.

And so, four, it is my parental responsibility to accept this and to help them to assimilate, to make sense of, to integrate all of the input or stimuli that they are receiving.

The most common reaction, therefore, of parents was, number one, I am embarrassed and uncomfortable with this information about sexuality, but I want this material discussed and included. It helps me as a parent precisely

because I am embarrassed and uncomfortable. I am embarrassed, but it is crucial that my kids see and hear this.

The minority reaction was, "I am uncomfortable or anxious or squeamish, but after reflecting on it in the context of a group discussion, I have come to accept it."

The smallest minority reaction was, "These specific topics are a threat, and I do not wish to have my children exposed to them."

I think what we can do is urge that kids stay on the straight and narrow path and don't look up in the jungle.

And, in fact, that is precisely what the Adolescent Family Life Education Act does. It says, We are only going to teach abstinence. Don't look up. And, in fact, that works with some.

I suggest to you that with the majority, for the 80 percent that CDC advises us, indeed, disregard that information, that it is ignored, that there are a significant number of young people who rebel against it and others who ridicule it and see it as adult denial.

I think there is another group of us as parents who say, Let's teach our children about the dangers, but only the dangers of sexuality. And I think that is perceived by young people as being unrealistic.

And what I heard discussed in part just as I came in at the end of the previous discussion is, Let's talk with our young children about the dangers and the delights of our sexuality. Let us be honest.

If indeed we are to send young people out into the jungle or adults out into the jungle, we will give them a training seminar. We will have a question and answer period with them. We will role play with them what to do in the event of an attack.

I would like to address what it is that places adolescents at risk, because indeed I rarely hear that discussed beyond the larger sociological issues that we have been appraised of.

And I suggest to you it is an intersection between their psychological or developmental needs and tasks -- the normal developmental needs that every adolescent has, which include the necessity of developing a sense of themself, the necessity of having a sense of connection with other people and the necessity of developing a sense of their own power and control over their own lives.

And it is the pursuit of self-esteem based on two sides of being lovable, being able to give and receive love and feeling some kind of satisfaction in one's competence of capability.

And as that intersects with the contemporary sociocultural world, we have a very dangerous circumstance.

I suspect for most of the adult population, we would say about our own sexuality education, Heaven forbid that my children should ever have to learn about sex in the bad way that I did. And that is in the relatively safe world in which you and I grew up.

So I think it is no surprise to us that when the Gallop Poll asks parents how many of you would like help in sexuality education, 79 percent say, Not only do we want help, but we want help from that institution that we really don't trust in the least with reading, writing and arithmetic; that we want help from the schools. We know that our parents must be in desperate shape.

Why then are kids putting themselves at risk? Because, indeed, their anticipated reward from that behavior outweighs the perceived risk. And what it is is excess anxiety which restricts and distorts the ability to perceive reality accurately, and it generates denial.

What works? What works is one of the things that I saw in my therapy office yesterday as a 16-year-old girl said to me that she and her boyfriend are indeed intensifying their relationship. They have been seeing each other for a number of months.

She anticipates it will indeed become sexual very shortly, and decided after talking with me that she would go home and speak with her mother about that and ask her mother what her recommendation was in terms of the appropriate kinds of birth control, what the family's medical history was and whether indeed she should go on the pill.

And decided that, indeed, that was a mature and responsible approach to her behavior. And she was able to do that. She is, indeed, one of the small minority of people whose parents have provided a forum so that young people can talk.

People make good decisions when they are able to talk about it. And parents wish to be the primary sex educators of their children, but they acknowledge that they need help.

And, therefore, they ask the schools to help. They ask their religious organizations for help. They ask youth-serving agencies for help, and they ask for help for themselves so that they can learn to talk with their children more effectively.

And they screamed out to Children's Television Workshop, Thank heavens you are helping us. We trust you. And we trust you to not impose your values, but to acknowledge that there is in this country a diversity and

a pluralism.

And I think one of the questions that I heard asked before, What do we do with that small group of people who find what it is that sexuality education does offensive.

And I think we acknowledge that we are vast and diverse and that there are even some people in this world, probably in this room, who don't even like ice cream. There are probably some people here who might even get sick, because they are allergic to ice cream. And I think we need to acknowledge that.

There are some people in some religions for which wine is anathema and other religions in which wine is a sacrament. And I think if we wait for universal approbation we will be waiting a long time.

We would like to focus on both a macro and a micro approach. I think on a macro level we need to acknowledge the erotaphobia that is pervasive in this country, which is predominately from the far right and which says sex is bad and dangerous and we must rein it in.

It is, indeed, in my view a fairly Freudian view, that in order for society to live, we have to hold on to our negative, dangerous impulses.

I think on a macro level we need to acknowledge

that condom ads are still kept off of network television even though shows on network television, This is a problem that we have with HIV spread and condoms are a wonderful solution to that. But we won't advertise them on our channel.

I think we need to acknowledge the homophobia of our nation and speak out and say, This may be part of your bigoted response, but it is indeed an inappropriate response in a democratic country.

I think we need to acknowledge that homophobia and erotaphobia are preventing getting information that we desperately need in terms of a teen sex survey.

For the last ten years in the community in which I have been teaching sexuality, which is an upper-middle class community in which the average student -- 90 percent of the students go on to college, over the last ten years more than two out of three young males and young females have engaged in sexual intercourse before they get into my eleventh or twelfth grade elective course.

Fifty percent of them, indeed, have showered with someone of the other sex. That is not a quicky in the back of the Ford. That is a luxurious sexual experience while mom and dad are out at work.

That is different from what most of us experienced as parents, so it is hard for us to understand

that.

I think we need to acknowledge that ads are sexual, and we need to develop programs for all teens both in school and out, heterosexual, homosexual, bisexual, for those who are virgins and for those you are sexually experienced.

I think we need to acknowledge that CDC's censorship of important explicit material is indeed wrong, as apparently courts have just determined. And we need to counter the lobbying of multi-million dollar fear-based organizations.

What do we do on the micro level? I think, as I suggested before, parents want to help, and we need to provide information for parents. The CTW program ends with a young woman sliding in to the car next to her mother and saying, Mom, I have got some questions.

And my sense was, as I have listened now to 30 different of my friends and patients, every one of them said, I learned stuff in that program that I didn't know. Many adults feel we are inadequate sexuality educators and they need some assistance.

I think we need to train adult leaders, and I think training is one of the key issues, for youth-serving agencies, for religious organizations and for schools. I think we need to develop comprehensive health education

and sexuality education.

I have prepared a review for the book, State of the Art Reviews in Adolescent Medicine, which will be coming out next month. And part of the research on sexuality education is dismal and says it doesn't work.

Part of the reason for that is that when they define sexuality education sometimes, they say to young people, Have you ever had a course that dealt with reproduction, and if your answer is yes, they presume you have had sexuality education.

We teach civics in grades kindergarten through twelfth and then only 50 percent vote. And I suspect many of us believe that of those who vote, almost half of them, or sometimes more than half of them, vote improperly or at least not the way that we would.

That is a very small success rate, 25 percent. And I have never heard anyone suggest that we stop teaching civics. What we say is we need to do better. We need to do it more thoughtfully. We need to do more of it.

We have not tried to do that with sexuality education. We need to provide young people with facts and information, but to recognize that, though that is necessary, it is not sufficient.

We need to deal with issues of feelings and

values and emotions and attitudes, because, indeed, those are important, and to acknowledge that in the pluralistic country we have, they will differ.

And I believe, most important, we need to legitimize communication, to say to people that sexuality is a legitimate topic to talk about. You need not shy from it.

One of my most exciting responses to my sexuality class a couple of years ago was the young woman who said, I learned in this course that it is okay to be 18 years old and still a virgin.

Part of the CTW research indicated that boys and girls have limited knowledge and misinformation about sexuality, and that indeed girls see sexuality as something that happens to them. They are the passive recipients of what changes go on in their body and what happens.

They are conflicted and fearful about their sexuality. They are already internalized the message that even discussing sexuality is off limits.

I think what we need to do is to give our young people a sense of control of their sexuality and of their lives.

If we legitimize communication, we empower people. We give them a way to learn information, to learn

about different value schemes, to share information and to share their own value schemes, to become empowered to feel good about themselves, to not be pressured into choices that a young person feeling good about himself might not make, but to make thoughtful choices and decisions.

One of the questions that was asked is, How can parents have children talk to them as openly as the children on the television program did. And my answer is very simply, Rhonda Wise, the young woman who was the female sex educator, and I took those questions and those young people seriously. And I think we need to do that with young people and sexuality.

Finally, I think we have some good models for sexuality education. There was research presented last fall and winter on programs by Girls, Inc. -- used to be Girls Clubs of America -- that demonstrated that a program that involves young people, that talks about their future, that gives them an opportunity to role play, that gives them an investment and a stake in what is going on for them, that provides an opportunity to talk with adults and to clarify their own values makes them much more able to retain control over their own lives and to make decisions that are in their best interest and those of other people.

Thank you.

DR OSBORN: Thank you. Glad to know that the

person for whom you substituted is well, because I am awfully delighted that you were able to join us. That is very powerful testimony.

DR. SELVERSTONE: Thank you.

DR OSBORN: Welcome, Pedro.

MR. ZAMORA: Hi, my name is Pedro Zamora, and I work for an organization called The Body Positive Resource Center in Miami, and it is a local AIDS organization.

What I do for them -- I am a peer educator on the program called POP and POP stands for Peer Outreach by HIV Positive People.

I am honored to be here today and I was very delighted when I was invited to speak, not because of the honor of speaking before the Commission, but because we were going to have a presentation from young people, from a teenager.

I find so many times groups of adults and so-called experts gathering around talking about what kids need to hear and what they know and do not know and they haven't been a teenager for 40 years. So I am very delighted to be here.

I come to you today as a person living with AIDS, and I do not take the term living with AIDS lightly. I also come as a teenager, although I am no longer a teenager. I just turned 20 this past March, and I found

myself going through a midlife crisis at 19.

For the past two and a half years, I have been going to the schools and speaking primarily to kids anywhere from fifth grade up about HIV and AIDS, sexuality, sex, death, drugs.

It has been the most enlightening experience of my life. I found out that I was HIV positive at the age of 17, my junior year in high school.

At that time, the most important question in my mind was what college I was going to go to and whether I was going to stay in town or not.

AIDS has changed my life completely. I find that as a educator -- not necessarily as a person who has AIDS, but as an educator, I find a lot of problems and obstacles that I am finding in trying to reach kids, in trying to reach our youth.

The first thing that I found out -- and I am just going to go down talking about a few problems that I have seen, and listening to them speak, I just started crossing off things that they already said.

The first problem that I found was that, if you look at most curriculums in the United States -- in the country, they want us, as educators, to speak to the kids in very general terms.

And that would be okay if the kids were talking

in general terms. But when I go to a school, and I have a kid say, If I have a cut in my finger and I am having digital sex or I am fingering my girl friend, am I at risk.

I can not sit back and say, Oh, yes, you could get it through sexual contact. So that was the first problem that I encountered in Miami and in the county we work very hard to put a curriculum in place that addressed that, and luckily it passed.

The second thing was -- that I found was -- and he touched on it -- was empowerment. And empowerment is very important for me. It is important that -- as a gay man. It is important as a person of color, as Hispanic. It is important as a person living with AIDS, and it is certainly important as a teenager or a young person.

If you look at the message that we are sending our kids, we are disempowering them. You are not old enough. You are not smart enough. In some cases, you are not good looking enough. You don't have the right accent. You don't have the right color. That is disempowering.

If we look how any of us learn anything or do anything, we have to empower ourselves to do it. We have to empower ourself to make the right choice. And we need to tell it to our youth.

We need to say, You are smart enough. You can

make the right choice, but the right choice for you, not for your parents, not for society, not for your teachers, but right choice for you. You have the power.

To me, on a personal point, empowerment came -- when I found out that I was HIV positive, all I kept hearing was that I was a victim. I turned on the TV and I was a victim. I read the newspaper and they were referring to people like me as victims.

So everywhere I turned, I was a victim, and I found myself acting like a victim. And when one very close friend and co-worker, Doris Steinberg, she one day said I was referring to myself as a victim. And she said, You know, I really hate that word.

And I couldn't understand why. And I came to realize that victim is disempowering. That I am not a victim; I am a person living with AIDS. So I could relate to that.

I find that so many things -- and this really bothers me a lot -- is that one question that I commonly get here and there is why do you do it. Why do you speak out? You are HIV positive. Why don't you just worry about that and why are you worrying about us?

And to me that is something that bothers me a lot, because -- especially when I go into inner cities I get that kind of reaction. They are expecting people not

to care. They are expecting people not to give, not to help them.

And to me, when I get that question, my answer is, How can I not. To me what they should be expecting -- that they should be surprised when somebody does not care, when somebody does not help them. But it is the other way around, and that is a sad statement in our society.

We need to give our teenagers a voice. We need to make them part of our problems. We need to make them part of the records. We need to make them part of a commission on AIDS.

Another problem is that we live in a society that we think that information or education changes behavior. That is not true. If information changed behavior, we wouldn't be drinking, we wouldn't be smoking, all of us would use our seatbelt, Ronald Reagan would not have been reelected.

The first thing for anybody to change their behavior is that they have to see themself at risk. If I don't see myself at risk, I don't have a reason to change my behavior.

When I was in seventh grade, I got me AIDS education. I had a doctor who came in in a three-piece suit, silver hair. We talked for about an hour and a half on the very medical terms. He talked down to us. He

never got questions and answers.

And I remember sitting there being sexually active and worrying about whether what I was doing was putting me at risk or not, but he didn't provide me with a forum where I thought I was not going to be judged and where I felt that I was going to get an honest answer.

So I just went back into my little shell and I walked out of that room hiding behind the fact that I was an honor student, that I was an athlete, that I was the perfect son, the perfect student, the perfect everything. And I hid behind that all the way to my junior year when I received a letter from the American Red Cross saying that one of the tests that they performed was positive.

We need to have conversations about AIDS. What I do in my presentations is I talk about AIDS, and I get a lot of questions and answers. I do not control the presentation. I do not give lectures. I just talk about AIDS. They ask a question. I give an honest and open answer. And I think that is very important.

Another thing is that in order for me to see myself at risk, I have to believe. I have to believe what the person is telling me. And, in order for me to believe, I have to understand.

I find so many educators that say the fact, but they don't say why the fact is a fact. No you cannot get

it from mosquitoes, but they never say why. Well, if I do not understand, then I am not truly going to believe. And for me to change my behavior, I have to believe.

Saliva -- one of the most common questions. Saliva has the virus. We don't have any cases. Why? If it has the virus, if the virus has been isolated, why? Why is it -- why can blood and semen give it and not saliva as well, if it is isolated in them?

The more they understand, the more they are going to believe. They more they are going to believe, the more they are going to modify or change their behavior.

Another thing is nobody is talking to them about the difference between sex and sexuality. There is a big difference. Nobody is talking about that.

We are treating sex as a physical thing. And, sure, sex is a physical thing -- part of it is physical, but it is not all physical.

There is an emotional, psychological parts of sex. And abstinence, of course, condom is going to protect them physically, but it is not going to protect them emotionally. And they are going to have emotions before, during and after sex. And we need to address that. We need to talk about that.

We need to talk about why have sex, why not

have sex. The only thing that most teenagers are getting today say no. Say no to sex. Say no to drugs. But nobody, most of the time, is telling them why to say, and they are certainly not saying how to say no.

So we need to talk about that. We need to talk about what are good reasons to have sex and what are not good reasons to have sex. And, of course, that changes from person to person.

I know a lot of 50-year-olds who shouldn't be having sex, because they are having sex for the wrong reason.

We -- talking about condoms -- in the last panel, they kind of talked about. We need to talk about the whole truth.

I received a letter from a friend -- a mother of a friend of mine who saw me on TV, and she wrote me a letter saying she was very happy. She had seen me on TV and she was very happy that I decided to help me, but why don't I say the whole truth.

And she encouraged me to read a pamphlet that she sent with the letter, to read it with an open mind. So I read it, and I did read it with an open mind. And it talked about condoms and about how we liberals are kidding our youth and we are not saying the whole truth. We are not talking about the fact that condoms are not 100

percent safe. That they fail 25 percent of the time, and all that stuff.

Well, if we are going to talk about whole truth, I could get any random 100 kids and I ask them, Are condoms 100 percent safe, and they say no unanimously. But when I ask them why not, nobody could say why.

So let's talk about why. Let's talk about they whys. Why aren't condoms 100 percent safe? Human error. They could break, they could fall off, the semen could come around it, but most of the time it is because of human error. You did not store it in the right place. You did not use it properly. So let's talk about that, but nobody is talking about that.

Another thing is that we are going to extremes. We are talking about not having sex or condoms. So we need to talk about the definition of sex. And if we look at the definition that our society -- regardless of whether you are 16 years old or 50 years old -- have with sex is penetration. If I don't have penetration, I didn't have sex.

Well, between the first kiss and penetration there are a lot of things. When I am asked the question of whether I am still sexually active or not, and I say yes, the kids are surprised. Because kids think -- main street America thinks that after an HIV diagnosis you

shouldn't be having sex and, you know, life is out the window.

When I tell them that I could be extremely sexual with a person and never put he or she at risk to getting the virus, they are surprised. When I tell them that I could be extremely sexual with a person and never use a condom and still not put he or she at risk to getting the virus, they don't believe it.

So we need to talk about out-of-course. We need to digital sex. We need to talk about fingering. We need to talk about masturbation. We need to talk about fondling. We need to talk about all those sexual things that they could do without putting themself at risk, but nobody is talking about that.

One thing that I find is that, as a whole, counselors in schools -- the only counseling that they do is about whether you should be taking math or honors English. There are very few circumstances that I have seen that they really deal with the issues that we as teenagers or as young people have to deal with.

When I announced to my counselor in my junior year that I was HIV positive I ended up counseling him. I say myself saying, Look, I will be okay. You know, this thing is not going to kill me. I have a few years ahead. I had to counsel him. I had to encourage him, and that

headache, I have something wrong, I go to mom or dad and they take care of it. So me, as a 17-year-old with HIV, which my father didn't know much about, I couldn't go to him. I had to do it on my own and that was tough.

Just one last comment. I know I have past my time. And that is about gay teens. I am very concerned about gay teens. It is frightening.

If you look at it, we all need to show our sexuality. We all are going to show our sexuality every day whether we like it or not. Heterosexuals show their sexuality in very simple ways, little ways that most of the time they take for granted.

If you look in a high school, heterosexual teens are showing their sexuality every day in very simple ways. They write in their folder, Peter loves Mary, Mary loves David. They write notes to each other. They get on the phone for three hours. They smile at each other. They hold hands. They kiss, they hug. A gay teen cannot do that.

A gay teen cannot hold another guy's hand. A lesbian teen cannot write Mary loves Sue in a folder, not without being threatened.

So the only way that we as gay teens, and as gay men and women, have of showing our sexuality is by actually having sex, and most of the time having sex in a

hidden place. So that is something that we need to address.

Thank you very much.

DR OSBORN: Thank you very much. I have suspicion you are doing a marvelous -- a lot of good for a lot of people with the clarity of your thoughts, Pedro.

MR. ZAMORA: Thank you.

DR OSBORN: Tim, welcome.

MR. TIM H.: Okay. I would like to preface by saying that I found out about this conference on Friday, and so I am not as prepared as I would like to be, and especially following that very eloquent testimony right there.

I would like to start off just saying that the last time I talked to you guys I showed you a young adult who had hemophilia and was infected with HIV, who was very confused and disturbed about not only being 21 and being middle aged at the same time, but also being confused about relationships and sex in general.

And then very soon after that I found myself another girl friend, or actually I was in the process of finding a girl friend when I talked to you, and -- because my other girl friend had broken up with me, basically because of HIV.

And I found myself forcing -- well, not

forcing, but pushing her to get into a very deep and committed relationship. And when I talked to my psychologist he said, Well, Tim, you are trying to force -- I mean, you are trying to eat a seven-course meal in five minutes and it is just not going to work.

A month later I went off to Ireland and hitchhiked and stayed there for two months. When I came back, I found myself faced with coming back and having an ex-girl friend that I was still in love with and a new girl friend who is very much in love with me.

And so what I did was I ran away to Boston where I didn't know anybody besides my brother, and I am still there. And trying to figure out what I am going to do with my present girl friend, who I am pretty much sure that I love, and she is going to Arkansas for grad school, and I don't know what I am going to do. So that is one of the decisions I am going to face when I get home.

I am telling you these things, because these are issues that every adolescent has to deal with, and these -- in different ways.

I am 22 now. I am not quite an adolescent, and these issues almost get more complicated with the more decisions that you have to make. And the older you get the more decisions you have.

And so with being adolescent you have really

got to address these issues soon, so they can deal with them. I am still not able to deal with all these things. And I try -- I do all these crazy things to attempt to cope with this bastard disease that is really -- as everybody here knows, it is really awful.

But, basically, I really feel that we have the responsibility to attempt to equip adolescents with the tools that -- to make them be able to deal with these situations that will help them in the future and be able to live with HIV and AIDS. And I think that is the most important thing that -- why everybody is here today.

And it has to be remembered that we are here to help -- well, to make sure that people with AIDS and HIV live and live well for the rest of their lives.

One thing that I think is stressed maybe too much, especially for people who are already infected with the virus is transmission. These issues are very, very important, but I think their emphasis has to be a little bit rethought, because, at least in my community, in the hemophiliac community and the people I have talked with, this has been beaten into our brains to the point where they are talking about erotic dreams and sexual dreams.

I have yet to have a dream where I have not been conscious of my HIV status. And every once in a while I think about that and I think about the cliche

about people in wheelchairs who dream they can run or dream they can fly, and I can't do that.

It is very confusing for me, and I think a lot of people feel the same way. And I also have a very close friend who has a repeating dream of seeing his girl friend in her grave, and he killed her.

And so these issues are already present in our brain, and I really think that this sort of emphasis is -- makes it extremely difficult to have a productive relationship, because as it turns out I, myself, and a lot of people I know have a classic alcoholic personality when it comes to relationships.

We constantly push away the ones that we love. We say to them, like, You are too good for me. Save yourself. Go out and find somebody who can make you happy and won't threaten your life.

And then after a while we will succeed and they will leave us. And we say, See, I told you that. I am unlovable. And even though I am conscious of this fact, I am right now pushing away my present girl friend. I am saying, Go ahead and go to Arkansas and be -- you know, like find somebody besides me, even though she has said to me, I want to spend the time with you that you have left. I don't care if you are going to die in two years, five years or 40 years. And I am aware of the risk I am taking

of being with you, but I am still willing to do it.

And somewhere deep down inside of me I can't let her do it. And I think part of the reason why I am still in love with my ex-girl friend is because she left me. And then that -- and so I respect her for doing that. It says, Well, you made the right decision. You left me. And so -- which makes it extremely strange, because I know all these things and yet I still do them.

And you guys have to excuse me for my jumping around, since I said I wasn't too prepared. I sort of wrote this on the airplane.

But right now we have a very angry and frustrated population. Adolescents and young adults have seen puberty change to middle age in a few short years. And we are a community that I feel is riddled with self-doubt and a sickening sense that we are doomed to a life alone.

And I think the issues of transmission are one that can be covered indirectly through direct empowerment of the community. And the word empowerment has been used a couple of times during this panel, and I think it is very important.

And I think this empowerment takes a little creativity. Adolescents is a community that is very, very hard to reach. I really feel that. I know recently

having been a teenager that I never wanted to go to any function, anything to do with hemophilia or AIDS. It doesn't concern me. I have got everything under control.

Because many people in this community are deep in denial. And I know everybody knows that, but I just want to reiterate that. Also, I think once adolescents get older and come out of their teens, they also -- once they face it, they also become somewhat paralyzed in their indecision to what to stuff into their short life. That they just realize that they are not going to live to be 50, 60 or whatever.

The traditional ways of getting through to young people really have to be reworked. The social worker taking the guys out for Putt-Putt and pizza is a good attempt and a nice start, but I really don't think it will get you too far.

In my experience, consumer based groups induce empowerment effectively and directly. I strongly feel that my community can help itself through things such as phone networking, support groups, involvement with HIV and AIDS organizations and summer camps.

As for summer camps, I have worked with the hemophilia summer camp very intensively in the past, and I have seen this as a very effective way of reaching adolescents, because you can teach them when they don't

know that they are learning, and that is the best way, I feel, to present important issues.

And I don't see how much more of a non-threatening atmosphere you can get than a summer camp run by older members of their own community. They see, Hey, there is this guy or this woman who has been through what I am going through right now. And it -- and they can't help but take advantage of that situation, especially if they are pushed along a little bit.

And I have -- I really don't see why this can't be extended into the rest of the HIV and AIDS community. Hemophilia camps have been around since 1969, and so the format happened to be there when HIV and AIDS came around, and we took advantage of that.

And I really think this is an opportunity for the rest of the HIV and AIDS community to take advantage of it as well.

And also with phone networks, especially with young persons living outside of large cities, the only way to talk with members of their community is by long-distance phone. And a lot of them just can't afford it, you know, or they don't think of it. They don't think they can take advantage of the phone.

But I think this is a very valuable source of support and to form support groups and to be able to

talk -- just to be able to talk with somebody who is in your situation at a time that you want to is very important.

I know that MANN and the Hemophilia Foundation of Michigan have set up a way for young people to -- for young people with hemophilia and HIV to meet regularly with conference calls. And I think that is a very good trend to start.

And I am not sure whether they have an allowance for individual calls or not, but I really think that they should and I really think that should be an outlet for everybody who is HIV positive and AIDS and who has friends around the country or just across the state that they want to talk to, because friendships can be formed and it can be very empowering to talk to somebody.

And, lastly, I think it is important that our community should be encouraged to form their own advocacy groups. I have this newsletter here called the Common Factor, which is put out by an organization called the Community of Ten Thousand, which I have recently gotten involved with.

And I think the gay community has done a fantastic job with forming their own groups. And the Community of Ten Thousand has borrowed very much from the gay community, and I would very much like to thank them.

And I have seen a very much -- a huge need for this. With our first newsletter that we put out, we had an incredible response from the hemophilia community and the AIDS community. And it is something that is coming from people who are directly involved with this disease, and so it is more trusted. It is taken as something more personal.

And I think the basically reason is because only consumers know what they really need. They have no one's interest to look after but their own. There is no drug companies. There are no care givers, no government. There is -- it is -- although, like National Hemophilia Foundation, or other groups -- they do have other constituents that they have to look after. And it is very important that the consumers have a voice of their own.

And I really think that this is a very effective way to improve everybody's life who is dealing with HIV and AIDS with empowerment and taking control of their own life and their own treatment.

And I would like to make the rest of my statements during the question and answering period. That is about all I have. Thank you.

DR OSBORN: Thanks very much, Tim. It is good to see you again, and keep up with how things are going.

We have -- unfortunately, we have actually run

out of time for question and answer, and I am not going to let that stand, but I think we need to be very brief, because we have a number of people who have signed up for the public comment period, and that already has to be quite brief. So let me take -- Jim, Larry.

DR. ALLEN: Thank you all for some very important testimony. Mr. Zamora, you touched on the subject, I think, in a new way for me about how difficult it is for a young person who identifies himself as gay or lesbian.

We have heard other speakers earlier, not at this session, but in other sessions. A young man in particular who was talking about the fact that as he recognized his homosexual feelings that he had nobody to turn to or talk to about it. And that created real difficulty for him.

I would like to have any of you address the issue of how we might better deal with this in our society.

Dr. Selverstone, how do you handle that in some of your classes or in the Children's Workshop, or what are some of the minority population perspectives on this, because of the different cultural and ethnic values that come into this.

DR. SELVERSTONE: I think the point you raised

is critical. A young African-American child who comes home from school might say to his or her parent, They called me names and they picked on me, because I am Black, or They picked on me, because I am Jewish or Irish.

And mom and dad can say, Well, that is okay, kid. We know what it is like. You know, we are Black. Mom is Black. Dad is Black. Our grandparents are Black. We have gone through that.

A gay, lesbian or bisexual person cannot come home and say to mom and dad, They picked on me, because I am gay. Mom and dad don't say, Well, that is all right. I am gay and your father is gay and we are all gay in the family.

That indeed homosexuality is -- constitute an invisible minority. And one of the things that we know about prejudice is that it thrives with ignorance. And so what we need to do -- I think the phrase, out of the closet, is an apt one -- is to say, Let's talk. Let's think about who we know who might be gay.

In my class for the last 15 years we have taken two full days, and in one day we bring in a fundamentalist minister to talk about a biblical interpretation of homosexuality as sin and why it is seen that way. And the next day we bring in a gay adult counselor to talk about what it was like for him to grow up.

And, in fact, most recently we have brought in a young lesbian woman who called and said, Bob, I was always upset that we had the gay man, but we never had a lesbian. I was in your class two, three years ago, and it occurred to me that now it is appropriate for me to share that with people.

And what happens is that at the end of that no one in class has ever said, That is it. I am going to go out and have a homosexual relationship. That gave me permission to do that. That is just what I have been waiting for.

What they say is -- most of them, I don't think that is for me. That is not my orientation. I think I am not going to do that, but I have a much clearer understanding of what that is like. I am not going to make those faggot jokes any more. I am not going to go by the gay bar in town and shout out things at the people who are there. I am going to start to talk to my peers about how offensive that is.

I think that is a public education process, and I think we need -- and I think you folks with your visibility and clout need to be in the forefront of saying, This is unacceptable behavior. We will not tolerate that kind of offensive behavior.

MR. ZAMORA: To me, out of anger, I came out to

my class about being gay. And it was my last class in high school and it was psychology, and I came into the class a week late.

And the first two days they spent getting a list of different topics that wanted talked about. And one of the topics put was homosexuality. It had nothing to do with it that I came two weeks into the class. It was already there.

What I found was -- when we were talking about homosexuality a lot of the macho attitude came out. You know, I don't want a faggot around me. The feeling that if you are gay, then you want to get into my pants just because you are gay, regardless of, you know, anything else.

When I came out to the class, one of the things that happened they talked about gay bashing. I had just had a friend who was gay-bashed and was very angry at that. And one of the students said that he had beat somebody up.

So out of anger I came out and said that I was gay. What I found was that, because most of the kids had been with me since sixth grade and knew me, they didn't -- the reaction was just questions.

And I found out the same thing with HIV. I provided them with a forum where they could as me anything

they want without me getting offended: that I was going to put my views, but I was going to allow their views.

So I got questions. Of course, at the time I was involved in a relationship and thefunniest question I got from them was, In your relationship with your boy friend, who is the man and who is the woman? So I said, Wait a minute. We are both men. There is no woman. But that is the kind of question that I got.

And I gave them the answer, and I talked about sexuality versus sex and about the fact that I am a gay man, but I don't necessarily like to act like a woman or dress like a woman or anything like that. There are some people who like that, but it has nothing to do with being gay.

Basically I gave them a forum where we could talk and have a conversation, and it was great. And I didn't get beat up. Nobody said anything offensive. One of the guys who -- it is real funny. I knew him since sixth grade, and we had taken a number of showers together. We were in the track team together, and we were kind of very close.

He at the beginning said -- referred to gay people as faggots. And after I came out, he said that he respected me a lot, and that meant a lot, because he is the stereotypical macho man.

So I think one way is to put forums where people feel free to ask questions and to have a conversation in a non-threatening environment.

DR OSBORN: Thank you. Larry, I am going to give you the last question. I hate to cut this off with such a rich source of comment before us, but I am afraid we have 15 people who want to make public comments between now and 1:15.

We have airplane things that press us, so if I could ask you to be brief with the last question, and then we --

MR. KESSLER: Okay. I have two questions. I think they can be answered briefly. They are sort of guideline questions.

Dr. Shervington, in terms of some of the comments you made about people of color -- youth among the communities of color and linking it to incarceration and so on, do you have any theories about what also seems to be going on in, say, the Anglo community among youth, especially gay youth, that sounds to me like we are on the same track in terms of increased activity that puts them at risk, lots of denial, or whatever.

And I have some theories, but I am interested in your theories as a psychiatrist and whether you have noticed that or see it -- a counterpart among white youth

in terms of people-of-color youth.

DR. SHERVINGTON: The comments that I made were -- I was really trying to focus on particular forces that are generally not identified as relates to homosexual activity, not necessarily being gay or straight.

My experience in working with a number of white gay men -- adults, not adolescents -- and also in working with a young adult prison population -- federal prison population which was primarily white at that point in time, was that a number of the issues of poverty are common in terms of what happens to young men.

One of the things that was very impressive to me in the prison situation was that the commonality was undereducation, poverty and, for lack of a better term, what I called polymorphous perverse.

These young men had had all kinds of early sexual experience prior to coming to this federal prison at any rate, and there was a great deal of sexual activity in that prison.

One of the things that also impressed me in thinking about sexual behavior as -- that is homosexual behavior as being less defined by orientation than by a number of other factors was a prisoner who shared with me the idea that when you don't have anything else to give to another man who has been particularly good to you, then

you have yourself to give to him, if he will have you.

And that was -- that dawned on me that one would think in that kind of way. So that giving of yourself sexually means a lot of things in a lot of different ways.

My own thoughts about the gay community in relationship to adolescents is that that is in some ways a very special community, if I might say that, in the sense that it is hard, I think -- it is probably a little bit easier today than it was some time ago, but I think that it is not easy for adolescents to indeed pull that together in as healthy a way as Mr. Zamora has on a regular basis considering the various forces within the community.

The idea of being isolated always impresses me, because growing up in the Black community and even today in the Black community, there are so many expressions of homosexuality that can be seen in one way or another, if you open your eyes to see it, so that you don't experience yourself necessarily as being singular.

DR OSBORN: Larry, I am going to have to ask your indulgence, if you could take your other question later --

MR. KESSLER: Okay.

DR OSBORN: -- because I am a little worried

that we really are way past time now. If that is all right with you, I think I had better proceed to public comment. Thank you very much.

Let me thank the panel for their really extraordinary testimony. We really appreciate the effort that you have made on behalf of our common cause, I guess. Thank you very much.

We are now heading for the public comment period, which -- as announced, and people have signed up to speak. And I am sad to say that there will only be two minutes per person, and I must enforce that.

Let me welcome anyone who has -- who would prefer or who would feel better to have a longer time to please submit written comments instead.

This is not a particularly -- we know this is not a particularly satisfactory circumstance for people to express themselves fully, and we urge you, if you can, to take advantage of the alternative, which is the -- which would be to submit written comments to the Commission, and we will try to pay close attention to them.

I would like people to take their comments to the central microphone and please understand, as we have to stop you at two minutes. So I urge you to try and put your thoughts in a very succinct way so that we can get your main idea.

Let's start with Dr. Hyslop. Excuse me pronunciation, if I don't get it right.

DR. HYSLOP: Yes. Thank you very much, Dr. Osborn, members of the Commission.

I want to speak as a physician and particularly as the principal investigator of the Tulane, LSU AIDS Clinical Trials Unit. You did receive some written testimony from us, and I only want to address one issue. And that is the concern about the adequate funding of adult clinical trial units.

As I am sure you are well aware, a recomputation was held in 1991. The funding decision was made in 1992. And of the existing 32 units, essentially 21 ended up being refunded and seven new ones were funded.

This is one of the sites of -- the existing eight sites which was not refunded, and we were given permission to continue for an additional seven -- excuse me -- seven of us were given permission to continue until the end of this fiscal year dependent on the adequacy of funding by the Congress and the President of the 1993 budget.

I would just like to indicate to you that we continue to be numbered 15 in the country in terms accrual to AIDS clinical trials. This is a sight that brings hope to the young people who were here speaking earlier about

access to effective therapies, both preventive and treatments.

And I am concerned that this topic has not received any attention nationally. The adult -- the numbers of adult clinical trials will decrease as of January 1 from 35 to 28, and that this will be a reduction from originally 32 down to 28 due simply to the issue of funding.

The funding crisis was brought about by a combination of factors. One, a major increase in the number of pediatric AIDS clinical trial units from 15 to 24 and the inadequacy of funding for the adult clinical trials programs.

This is a very important issue and I think it deserves your attention. Thank you very much.

DR OSBORN: Thank you very much for redirecting our attention to that. We do have your written testimony.

Micelle Heally followed by Chris Love. Perhaps I can have people ready to come up.

(Pause)

VOICE: A large number of those people have decided not to speak.

DR OSBORN: Fine. Well, maybe what I will do, then -- thank you for helping me with that. I will read names, and if there is somebody -- I will watch for a

second -- and then go on. That will help us with our time constraint, because we do want to be able to hear people.

Chris Love, Frank Aqueno.

MR. AQUENO: My name is Frank Aqueno. I am a writer and performance artist here in New Orleans, originally from New York City.

I come to urge each and every member of the AIDS Commission to resign. I speak for a small segment -- or a segment of the queer community, a segment which is asking questions like, and I quote -- if the FBI is here, I am quoting, "If I am ever brave enough to murder Jesse Helms, will you hand me the gun to carry out the deed? Will you hide me from the law once it is done?"

Where is Magic Johnson? Why is he not here? I come to tell you that he is not our hero.

Dr. Allen, you asked what can be done for homosexual youth who have no one to turn to. Well, you can tell Magic Johnson when he goes on Arsenio Hall and says, I am not gay and gets a standing ovation for saying so, that thousands of gay youth, particularly Black gay youth, close the closet doors tighter.

I understand -- I am going to make this short, because the message here is the only thing you can do. Now, I went to the library this morning. I have -- you know, like when I hit the computer button on AIDS

Commission, you know, and the report thousands -- not thousands, but hundreds of things flew out in terms of AIDS Commission recommends this, AIDS Commission recommends that.

That was all a year ago. Nothing has been done. Congress has done nothing. The President has done nothing, except to appoint what appears to be a mouthpiece, someone who looks good, someone who gets a lot of attention. Where is he?

Now, I understand when confronted yesterday, although I wasn't there, some members of the Commission who were told to resign, that that is the only honorable thing left to do -- it is the only thing that will cause anything to happen a year later.

You must embarrass this Congress. You must embarrass this President. That is the only thing that appears to work. We know that from our own activism. Nothing has been accomplished by asking for it.

Now, when confronted yesterday many -- or, some of you said, Well, what will happen if we resign. Who will take our places? It could be worse.

And I would like to just finish by reading from a poem by Bertold Brett [phonetic], Gotham [phonetic] of the Budda taught the doctrine of greeds wheel to which we are bound and advised that we should shed all craving and

thus undesiring enter the nothingness that he called Nirvana.

Then one day his pupils asked him, What is it like, this nothingness, Master. Everyone of us would shed all craving, as you advised, but tell us whether this nothingness which then we shall enter is perhaps like being at one with all creation. When you lie in water, your body weightless at noon, unthinking almost, lazily lie in water or drowse hardly knowing now that you straighten the blanket going down fast.

Whether this nothingness then is a happy one of this kind, a pleasant nothingness, or whether this nothing of yours is merely nothing, cold, senseless and void.

Gotham the Buddist was silent and then said nonchalantly, There is no answer to your question. But in the evening when they had gone, the Buddha still sat under the breadfruit tree and to the others, to those who had not asked, addressed this parable.

Lately I say a house --

DR OSBORN: Mr. Aqueno --

MR. AQUENO: I am taking Chris Love's time.

DR OSBORN: Okay. That will, however, put you out of time now.

MR. AQUENO: Or Micelle's time.

DR OSBORN: I have given you quite a bit of

time.

MR. AQUENO: Lately I saw a house. It was burning. The flame licked at its roof. I went up close and observed that there were still people inside. I opened the door and called out to them that the roof was ablaze, so exhorting them to leave at once.

But those people seemed in no hurry. One of them, when the heat was already scorching his eyebrows asked me what it was like outside, whether it wasn't raining, whether the wind wasn't perhaps blowing, whether there was another house for them and more of this kind. Without answering I went out again.

These people here I thought need to burn to death before they stop asking questions. Truly, friends, unless a man feels the ground so hot underfoot that he would gladly exchange it for any other sooner than stay, to him I have nothing to say.

But we too no longer are concerned with the art of submission, rather with that of not submitting and putting forward various proposals of an earthly nature and beseeching men to shake off their human tormentors, we too believe --

DR OSBORN: I am sorry, but I am going to have to interrupt you now. We have not been able to --

MR. AQUENO: I have three sentences left and I

am going to finish them.

We too believe that in those who in face of this plague go on asking too long how we propose to do this and how we envision that and what will become of their savings and Sunday trousers after a revolution, we have nothing much to say. Resign, resign, resign, resign.

DR OSBORN: Thank you, Mr. Aqueno. The next speaker is Rea Amore. Mark Gonzales. Mark Durham.

MR. DURHAM: Members of the Commission, yesterday, I don't know if you know, I was there at the school -- present at Carver High. I would like to say that I would hope that you take to heart what the students said.

Condoms, safer sex education needs to be implemented in a high school level and an elementary school level and the junior high school level. Safer sex and condoms are what the students need to curb this disease.

As you listen to the children you talked about having sex during their adolescents, talking about their emotional stress, the physical stress we have on them, if condoms were readily available to them and in schools of all nature, I think later on in adulthood they could get used to those practices of safe sex.

Now, as part of ACT-UP in New Orleans, I too

would like to ask the Commission to resign, because I feel the Commission is just a puppet on the behalf of the George Bush administration. So resign. Thank you.

DR OSBORN: Dr. Susan Abdalian. Excuse me, again, for pronunciation.

DR. ABDALIAN: It is nice to see you again, and I was glad to be able to meet many of you yesterday. I would like to make actually just two or three points.

Number one, I was glad to see Mr. Zamora here. I think our gay and lesbian youth need some leadership in the White House, in our professionals as well.

In our community here, people are afraid to start groups for kids who are either identified or questioning about their sex and their sexual orientation, because they are afraid of ignorant prosecutors getting after them.

That makes it very difficult to provide services for these kids who may need a safe space, a place that -- where they can look at and test out what their sexuality is about outside of genital sexuality or out of having intercourse in a dark place or away from some sort of society.

Another thing -- the other things that I wanted to mention, though, is that we have -- it takes common sense to deal with teenagers. I have been in this

community for five years, and the one thing that I know that you need is just plain common sense. We know how to treat teenagers. We know what we need for our own kids. We need to provide the same things for all kids in the community.

It is the poorest teens that tend to be hit the hardest by all the violence of our society. The number one cause of death for my patients is murder. When they come to me and say, Oh, well, condoms, so what. You know, I know I could get condoms and I know I could use them. Who cares? I could get murdered tomorrow. I don't want to be bothered. Thank you.

I understand that. And when you have a cousin and a aunt and an uncle who have been murdered, it is very difficult to be very immediately affected by something that hides itself for years before you become sick.

We know what to do about trying to instill some self-esteem. Kids need a place in society. We don't need the media telling them that they are hypersexual animals and coupling sexuality with violence as we do.

Teenagers need to know themselves to be productive members of society, and we need to make a place for that.

People have talked about youth corps for years, making sure that kids have a place to give to others,

because they have outrageous optimism. I don't understand where this optimism comes from. Maybe I forget my own youth, but it is wonderful and we need to take hold of that and feed it.

And that is all I have to say. Thank you.

DR OSBORN: Thank you, and thank you for your wonderful work. We were most impressed.

Mark Simmons? Cornelius King?

MR. KING: Members of the National Commission on AIDS and other distinguished guests, I am going to say good afternoon.

My name is Cornelius King, and I am a person living with AIDS. I was officially diagnosed with HIV on March 5, 1987. I will never forget that day to receive the news that I was infected with this virus only spelled one thing to me, and that is death.

As many of us who receive such devastating news, I slipped quickly into denial. However, after my first illness, I realized then that I could no longer continue to deny.

After waiting months to be accepted in a clinical trials unit in Washington, D.C. and getting sicker by the day, I sold my house, I gave up my career, and I sold the furniture literally out of my living room, and most of my possessions, and I returned here to New

Orleans, my home, to die.

Shortly after moving here, my cousin, who was very active in AIDS volunteerism, encouraged me to proactively seek out treatment for my condition. He stood with me. He, as well as my family members and concerned friends, supported me.

I will never forget this, because at that time I was in tremendous and great need of compassion and support.

I had my first appointment in November 1988 at the C100 Clinic in Louisiana Medical Center. After a period of evaluation, assessment and other tests, I was asked if I would like to participate in a clinical trial. I was carefully explained what the trials were about and informed of the side effects and other pertinent data.

I officially began in the Tulane/LSU Clinical Trials Unit in February of 1989. By the summer of 1989 I was feeling better and I had gained 30 of the 41 pounds that I had lost.

I am convinced that the therapy of AZT and DDC, along with good monitoring, good health care has kept me alive. I am sure that you can understand that when anybody, including Dr. LaBella, Dr. Sullivan or President Bush slightly suggest cutting funding for AIDS or cutting the funding of the Tulane/LSU Clinical Trial Unit, I get

angry -- very angry.

Why are you so angry you may ask. In the past year, I have carried 12 caskets, attended 30 memorials and held the hands of friends as they have passed away. And all the time I wonder, Will I be next.

However, my struggle with this disease is not why I am here. Yes, it is a personal tragedy for me, my family and my friends.

More profoundly, I am here for countless others who have HIV, who may or may not be aware of their health status or who may just shy away from speaking openly for fear of rejection and various other consequences.

Louisiana ranks eleventh nationwide with its current total of more than 3,000 cases of adult/adolescent AIDS. New Orleans alone has in excess of 2,000 cases.

For a variety of reasons, I personally believe that the reported cases of AIDS and HIV is lower than what we actually see.

In my judgment, only one comes to mind that when you talk of closing or cutting an AIDS clinical trial unit. That word is criminal.

The closing of the Tulane/LSU Clinical Trials, which has a proven five-year track record of quality AIDS clinical research, denies access for over 3,000 Louisiana residents with AIDS and the estimated 30,000 asymptomatic

HIV positive individuals to on-going clinical trials.

Decisions with regards to ACTU also affects thousands of individuals from the Gulf Coast Region -- Florida, Alabama and Mississippi -- who regard New Orleans as the closest and most readily accessible major medical center with an national reputation for the treatment of HIV/AIDS.

In closing, I would like to take this opportunity to thank and recognize the wonderful work that has been going on in our community based organizations.

While we appreciate what the federal government has done thus far, we certainly believe that it is not enough. However, we have not waited for the government to do everything. It is through hundreds of volunteers, fund raising efforts and events, and pure dedication that people with AIDS in this community have been helped.

Therefore, may I suggest to you, President Bush, that you should consider the tremendous efforts of the NO/AIDS Task Force, the New Orleans People with AIDS Coalition, Community Relief For People With AIDS, ACT-UP, Fuzzy's Boys and Girls and Project Lazarus.

Wouldn't it be encouraging to people with HIV and AIDS if the President would name these organizations as points of light. Thank you.

DR OSBORN: Thank you very much. I would like

to urge you to send that as a letter as well. We are very pleased that you have taken the time to deliver that to us.

Patrick LeBlanc.

MR. LeBLANC: Ladies and gentlemen, I am here to discuss the Bush Administration's decision to shut down the ACTU here in New Orleans.

When Magic Johnson announced that he was HIV positive, Vice President Quail came out and said, Wouldn't it be great if there was a cure by the time Magic Johnson came out with AIDS.

Yes, it would, but wouldn't it be great if the Bush Administration kept the research programs funded so that that cure could be found.

The ACTUs work. They need to be kept open. You all probably all know that when a person -- that a normal person has a thousand T-cells and that when the T-cells get down to 500 they put on AZT. At 200 they put you on Pentamidine [phonetic], and at 50 they put you on whatever they can shove down your throat.

I am proof that the ACTUs work. My T-cell count last month was four, not 400, not 40, but four -- one, two, three, four. I don't even look like I have got AIDS. I can walk around. I can move. I can breathe freely. I have never been hospitalized. I have never had

an opportunistic infection.

The ACTU is cost effective. The drugs that they supply me and the care that they supply me costs a lot, lot less than if I had had to go into the hospital for two or three weeks.

Part of what is so galling about the government's decision to shut down the ACTU is that they want to do it to keep open programs that we know do not work, like the Star Wars thing or the B2 bombers, you know.

Why does he want to do that? Closing down the ACTUs save money for things that don't work. But like how many dollars and nickels and quarters was Ryan White's life worth? You know, if Bush had cut one B2 bomber and put that money into AIDS research, Ryan White and Kimberly Bergalis and literally thousands of others might still be alive.

It is the Commission's moral responsibility to provide leadership on AIDS related issues. I am not going to call on your to resign, but Mr. Bush has ignored your recommendations and your reports across the board.

Keeping this in mind, I would like the Commission to come out and openly and publicly endorse a presidential candidate, the one who it believes would do the most to promote knowledge and research for people with

AIDS.

I am probably going to die of AIDS, because the government keeps cutting down the research programs. When I die, I want a quilt patch to be made for me for the AIDS memorial quilt. What I want it to say is, You who are still alive, what is important? And, while you are still alive, what are you doing about it?

And I would like to ask that question of you all, too. What are you doing about it while you are still alive? Thank you.

DR OSBORN: Thank you, Mr. LeBlanc.

Norma Porter?

MS. PORTER: Hello, I am happy to be able to speak to you all today from the ACTU -- Tulane/LSU ACTU here in New Orleans. I am the head nurse, and I have come to represent the other nurses in our group, and this is the message that they send to you guys.

On behalf of the Tulane/LSU AIDS Clinical Trials Unit, we as nurses recognize the tremendous need for this viable program.

The news of defunding for seven existing units across the United States caused a great disruption in the future care of HIV infected persons. As the news was received, many concerns were expressed by the patients and their families regarding the loss of funding.

Nursing captured some of those views as the patients expressed shock, acute anxiety, despair and anger.

However, the most pressing concerns were related to issues such as the quality of their lives, the length of their lives and their overall future.

With the initial defunding patients felt deserted as expressed by statements such as, I feel like the rug is being pulled right out from under me.

With continued funding, patients have the choice of participating in clinical trials which gives them the freedom to choose, a sense of empowerment. And our patients made commitments to dedicate their precious time and effort in hopes of new scientific development.

Any disruption in the ability to complete clinical trials causes the patients to feel that their contributions are not acknowledged.

Funding for the Tulane/LSU ACTU serves patients from various locations in Louisiana, as well as neighboring states. Without continued funding, financial concerns become paramount among patients and families that we serve.

Many of our patients lack medical insurance, are unable to work and cannot afford health care and the medicines that we provided for them. Therefore,

travelling to another ACTU site would be impossible. The Tulane/LSU ACTU provides a solution for these financial concerns.

Presently we are functioning at full capacity until further notice of future funding. Recently we have received partial funding through December 31 of 1992. Since the partial refunding, we have restored the hope to our patients and their families by allowing enrollment to long awaited studies.

We are able to offer our services to many new patients as well as to former patients. There are clinical trials available to the very ill and the newly-diagnosed patients.

We are now able to service the mothers who are released from the pediatric clinical trials upon delivery of their babies, and that would not be afforded to them had this clinical trials been closed down.

We are open to referrals from health care providers, educators and community agencies. The recent influx of referrals and abundance of new enrollments to clinical trials demonstrates the viability of this valuable and much needed program.

And I would just like to say, too, that we had a mother that was going to be able to speak with you guys, and her daughter has been on clinical trials with us now

for about two years, and she is dying, and she is not able to come here. But she did want us to express her concerns and just wanted to be able to share with you the importance of this program.

Thank you.

DR OSBORN: Thank you very much. Before we close -- that is the last person here to testify -- I wanted to mention that Stephanie Edwards from Congressman William Jefferson's office was kind enough to come and bring us a written statement.

I am not going to read all of it, but the reason that Congressman Jefferson is not here is that he is at present testifying at the House Appropriations Subcommittee on Labor, Health and Human Services at the Rayburn House Office Building in Washington asking for restored funding of the seven ACTUs.

So I thought that would be an important comment to make in the wake of the impressive testimony of several of the people in the public comment period.

With that, the hearing is adjourned, and I appreciate all of your attention and help with our work.

(Whereupon, at 1:30 p.m., the hearing was adjourned.)

C E R T I F I C A T E

HEARING NAME: Sex, Society, And the HIV Epidemic

LOCATION: New Orleans, Louisiana

DATE: May 19, 1992

I do hereby certify that the foregoing pages, numbers 166 through 322, inclusive, are the true, accurate, and complete transcript prepared from the verbal recording made by electronic recording by Sandra McCray before the National Commission on AIDS.

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